HOSPITALS

THE USE AND SAFE HANDLING OF ISOTOPES

—Betram V. A. Low-Beer, M.D.

MEDICAL BEDSIDE TEACHING AND THE PATIENT

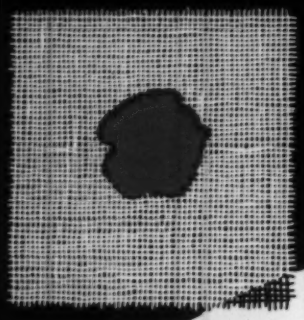
—Jack Karpas, M. B., Ch. B.

GUIDE TO A PLANNED SAFETY PROGRAM

—James E. Ludlam

DECEMBER · 1955

The Journal of the American Hospital Association



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1. Owings, C.B.: The Control of Postoperative Bleeding with Adrenosem, Laryngoscope, 55:31 (January) 1955.
2. Peele, J.C.: Adrenosem in the Control of Hemorrhage from the Nose and Throat, A.M.A. Arch. of Otolaryng, 61:450 (April) 1955.
3. Riddle, A.C., Jr.: Adrenosem Salicylate: A Systemic Hemostat, Oral Surg., Oral Med., Oral Path. In press.

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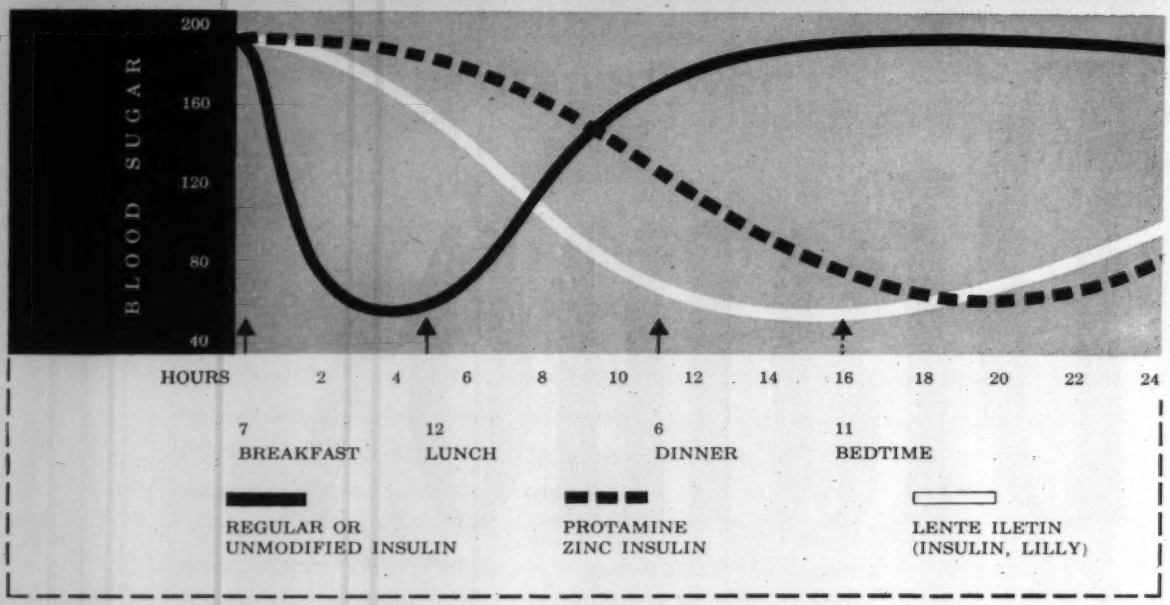

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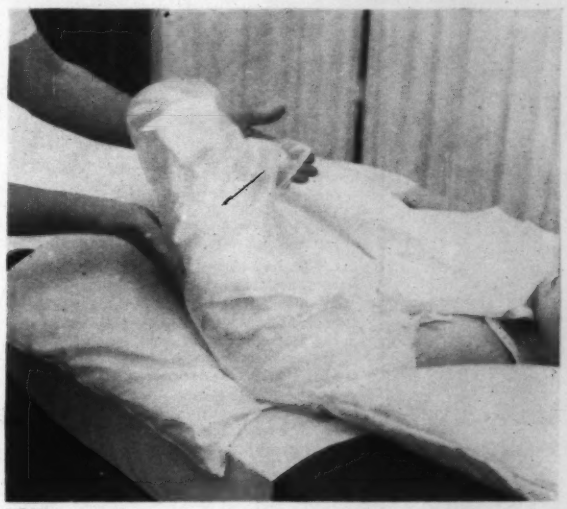

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OTHER MEETINGS

(THROUGH NOVEMBER 1956)

American Protestant Hospital Association—February 9-10; St. Louis (Hotel Jefferson)

Annual Conference of Blue Cross Plans—April 8-12; Hollywood Beach, Fla. (Hollywood Beach Hotel)

Catholic Hospital Association—May 21-24; Milwaukee (Public Auditorium)

REGIONAL MEETINGS

(THROUGH NOVEMBER 1956)

Association of Western Hospitals—April 23-26; Seattle (Olympic Hotel)

Carolinas-Virginias Hospital Conference—April 12-13; Roanoke (Hotel Roanoke)

Maryland-District of Columbia-Delaware Hospital Association — November 19-21; Washington, D. C. (Shoreham Hotel)

Middle Atlantic Hospital Assembly—May 16-18; Atlantic City (Convention Hall)

Mid-West Hospital Association—April 25-27; Kansas City, Mo. (Hotel President)

New England Hospital Assembly—March 26-28; Boston (Statler Hotel)

Southeastern Hospital Conference—April 18-20; Miami Beach

Tri-State Hospital Assembly—April 30-May 3, Chicago (Palmer House)

Upper Midwest Hospital Conference—May 23-25; St. Paul (Auditorium)

STATE AND PROVINCIAL MEETINGS

(THROUGH MAY 1956)

1955

Florida Hospital Association—December 7-9; St. Petersburg (Soreno Hotel)

Illinois Hospital Association—December 1-2; Springfield (Abraham Lincoln Hotel)

Missouri Hospital Association—December 12-14; St. Louis (Hotel Jefferson)

Hospital Association of Rhode Island—December 8; North Providence (Our Lady of Fatima Hospital)

1956

Alabama Hospital Association—January 26-27; Birmingham (Tutwiler Hotel)

Iowa Hospital Association—April 26; Des Moines (Hotel Savoy)

Kentucky Hospital Association—April 3-5; Lexington (Hotel Phoenix)

Louisiana Hospital Association—May 24-25; New Orleans (Jung Hotel)

Massachusetts Hospital Association—May 10; Boston (Statler Hotel)

New Jersey Hospital Association—May 16; Atlantic City (Convention Hall)

New Mexico Hospital Association—March 12-14; Albuquerque (Hilton Hotel)

Hospital Association of New York State—May 16-18; Atlantic City (Hotel Claridge)

North Dakota Hospital Association—April 24-25; Bismarck (Grand Pacific Hotel)

Ohio Hospital Association—April 9-12; Columbus (Deshler-Hilton Hotel)

Hospital Association of Pennsylvania—May 16-18; Atlantic City (Convention Hall)

Puerto Rico Hospital Council—January 15; San Juan (Caribe Hilton Hotel)

South Carolina Hospital Association—January 21; Columbia (Wade Hampton Hotel)

Texas Hospital Association—April 3-5; Dallas (Statler-Hilton Hotel)

Wisconsin Hospital Association—March 15; Milwaukee (Hotel Schroeder)

AHA INSTITUTES

(THROUGH MAY 1956)

1955

Nursing Service Administration Institute—November 28-December 2; Minneapolis (Radisson Hotel)

Safety Institute and Workshop—November 28-December 2; Washington, D. C. (Woodner Hotel)

Hospital Personnel Institute—December 5-9; Detroit (Statler Hotel)

Medical Record Library Personnel Institute—December 5-9; Dallas (Statler Hotel)

Laundry Management Institute—December 7-9; Kansas City, Mo. (President Hotel)

(Continued on page 154)

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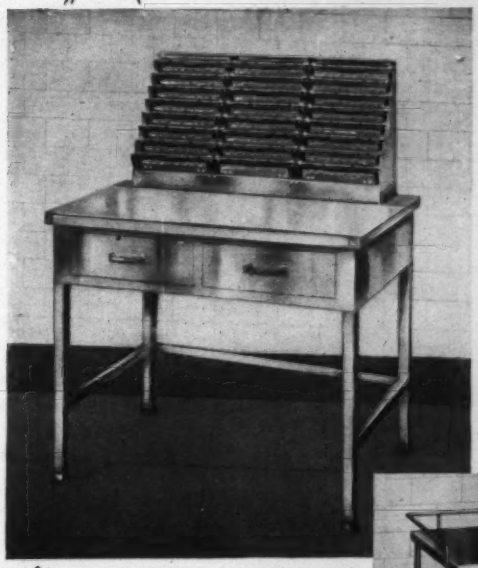

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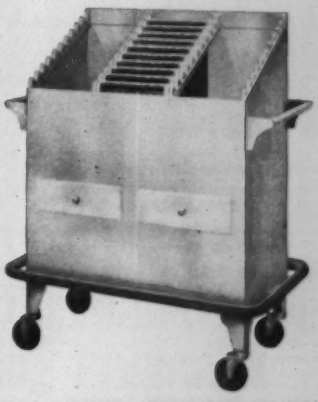

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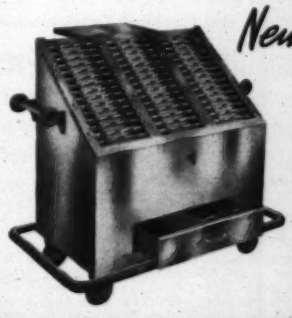

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introducing the authors

A health program for employees
by Helen A. Reischl, R.N.

MISS REISCHL points out that although there is no custom made medical and health program which suits the requirements of all hospitals, no hospital is too large or too small to carry out the objectives of a sound health program. She says that health programs have paid dividends in improved employee health, improved morale and reduction in absenteeism.

An occupational health nursing consultant for 13 years, Miss Reischl has been in a position to observe the changing trends in health promotion and health maintenance programs for more than a decade. She is a graduate of the School of Nursing, St. Agnes Hospital, Fond du Lac, Wisconsin and was granted her Bachelor of Science Degree in Public Health Nursing from Marquette University College of Nursing, Milwaukee.

MISS REISCHL

MR. LUDLAM

Guide to a planned safety program
by James E. Ludlam

MR. LUDLAM, a specialist in hospital law, reports in detail the experience of 120 hospitals which are participants in the California Hospital Association's group liability program. As general counsel for the California Association, and as attorney for 20 individual hospitals, Mr. Ludlam has had intimate contact with the complex liability problems besetting both hospitals and insurance companies.

DR. KARPAS

A graduate of Stanford University and Harvard Law School, Mr. Ludlam is a member of the Los Angeles law firm of Musick, Peeler & Garrett. He is general counsel for the Hospital Council of Southern California; board member, secretary and general counsel for Hospital Service of Southern California and a member of the American Hospital Association Committee on Insurance.

Medical bedside teaching and the patient
by Jack Karpas, M.B., Ch.B.

DR. KARPAS was graduated from the University of Cape Town (South Africa) Medical School in 1931. After serving his residency, he practiced in Parow, Cape Town for 20 years. During this period he was a municipal counselor and served a term as mayor.

In 1951 he emigrated with his family to Israel where for 18 months he practiced as a pediatrician in Haifa. In September, 1952, he joined the Hadassah Medical Organization as deputy director and director of its hospital services. This organization, which is supported by Hadassah, the Women's Zionist Organization of America, includes the University Hospital in Jerusalem, the Negev Hospital in Beersheba and the Tuberculosis Hospital in Safed.

In 1955, he spent some time studying hospital administration in the United States.

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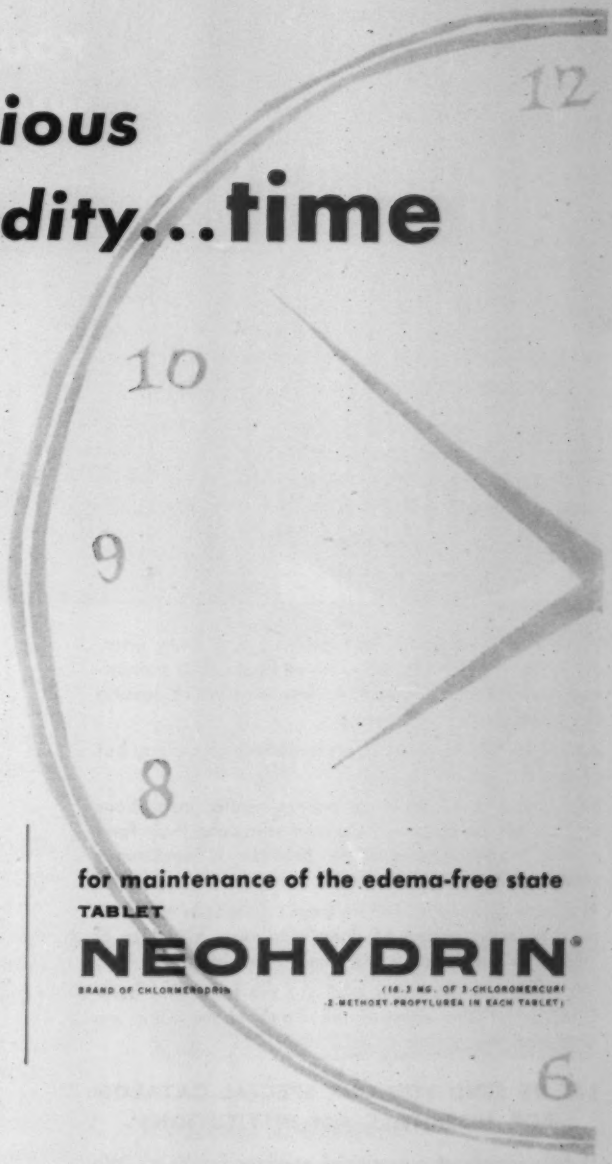

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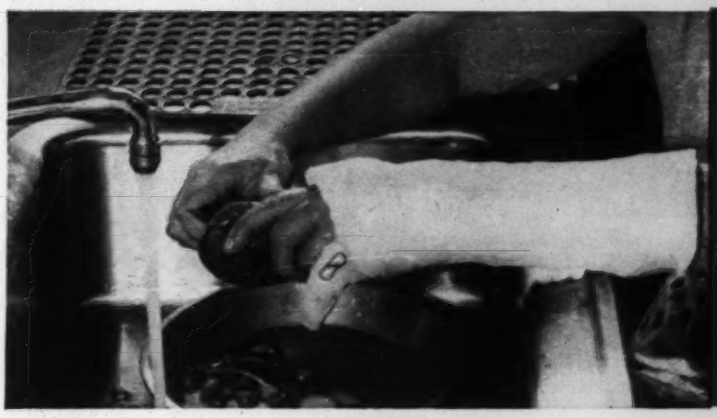

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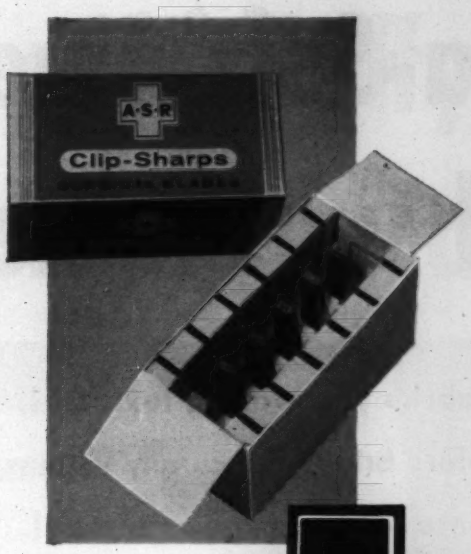

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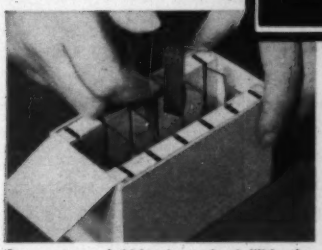

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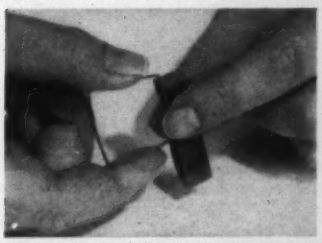

Grasp the wire clip between thumb and index finger and squeeze the wire. This releases the tension and enables the blades to be easily removed from the clip.

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New Armour discovery gives <u>all</u> fabrics you wash a luxurious, soft finish! Makes whites whiter, colors brighter. Actually softens, blues and brightens in a single rinse for just pennies a load!

Now VELVA-SOFT, the miracle fabric softener, has new BLU-BRITE added—Armour's exclusive combination fabric blue and brightener. Makes VELVA-SOFT the only product in the world that softens, blues and brightens everything you wash—does all three in a single rinse! Towels come out nearly twice as thick and fluffy. Muslin sheets become as smooth as percale. All white goods come out gleaming and snowy white, and colors are brighter than ever! What's more, fabrics actually last longer, wear better when they're rinsed in new VELVA-SOFT!

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Diapers and surgical linens are softened and sanitized! New VELVA-SOFT containing BLU-BRITE sanitizes as it softens diapers. Diaper rash bacteria (bacillus ammoniagenes) are stopped before they can cause irritation. Surgical linens maintain this sanitized treatment from one wash to the next.

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New VELVA-SOFT softens fibers and gives fabrics a smooth, soft finish. Makes even the roughest muslin sheets feel as smooth and luxurious as percale!

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a soft, fluffy finish -brightens and blues, too!

HERE'S PHOTOGRAPHIC PROOF!
This is an unretouched photograph. The towels at left were washed and given an ordinary rinse. The towels at right were washed the same way but *rinsed in new* VELVA-SOFT! They're nearly twice as fluffy.

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opinions

Hospitals abroad

TO THE EDITOR

Dear Sir:

I RECENTLY vacationed abroad. I could not divorce myself entirely from business and spent some time learning about hospitals in the countries I visited. Besides attending the Congress of the International Hospital Federation in Luzerne, Switzerland, I visited several hospitals in Stockholm, Sweden.

In an appointment with Mr. M. E. Molander, director in charge of the Central Hospital Planning Bureau for Sweden, I learned two things that might be of interest to your readers.

General hospitals are generally owned and operated by the County Councils or the bigger cities and the university hospitals in Stockholm (Karolinska sjukhuset and Serafimerlasarettet) and Uppsala (Akademiska sjukhuset) only are owned and operated by the State. The mental hospitals, on the other hand, are run by the State except the ones in Stockholm, Gothenburg and Malmo. It is my understanding that the planning functions for the state-owned hospitals are concentrated in the Planning Office in Stockholm.

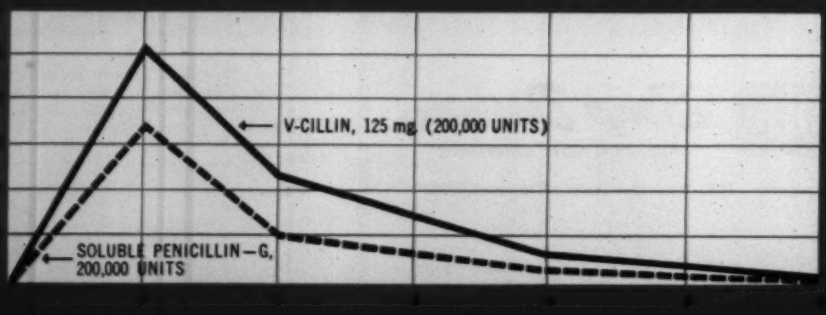
We also discussed what Sweden is now doing in hospitals for civil defense, and I learned that according to law, all hospitals must have air raid shelters available on hospital property and many have already complied. In existing hospitals, shelters sometimes have been built in granite cliffs which may be nearby. For new hospitals, however, and for hospitals where such work can be planned, a sub-basement will be built.

The shelters are intended to serve a two-fold purpose; as an area to which patients can be evacuated when an alert is sounded and as a place to use as an emergency treatment and dressing station once a bombing raid is over and the patients have been evacuated.

In the new hospitals air raid shelters include the following: one square meter or approximately nine square feet per patient; gas proof construction; ramps for approach, and an area divided into

NEW SUPERIOR ORAL PENICILLIN

V-CILLIN



smaller "rooms" to avoid the appearance of confusion and to provide for some desirable segregation on a medical basis.

Protection against the destruction of the A-bomb or H-bomb cannot be provided in so called "normal" sub-basement shelters. Planning is proceeding on the basis that such protection can be achieved only in granite cliffs or in special bunkers.—ROBERT V. FAY, *assistant administrator, Bridgeport (Conn.) Hospital.*

EDITORIALS FROM OTHER JOURNALS

The following excerpt is from an editorial that appeared in the October, 1955 issue of *The Journal of the Indiana State Medical Association*. Statistics from the Administrators Guide, Part II of August, 1955 HOSPITALS were quoted extensively at the editorial's outset and formed the base for these conclusions.

THESE FACTS AND FIGURES present a tremendous story, one in which hospital administration and doctors alike can take pride. Approximately half of the hospitals are voluntary. They were built and organized on a voluntary basis, and are contributed to sufficiently to allow them to continue on an income from patients of 90 per cent of their expenses.

They care for the great majority of the acute short-term cases. Year after year they have decreased the hospital stay without interfering with the patient's recovery. They have increased their admissions, and have rendered good service in spite of increased demands on personnel and a decreasing supply of personnel. They have stubbornly and adroitly avoided a substantial part of the general increase in the cost of living, and in terms of purchasing power today, offer the public its biggest bargain. They offer more in terms of the 1935 dollar now than they did then.

All this has been accomplished by an extremely complex operation of which the hospital is the focal center. Advances in medicine and surgery, new drugs, prepayment plans for medical expenses, good hospital management, and devoted service on the part of all the people who are concerned with hospital care, have all contributed to this remarkable record.

During the year 1955, one out of every eight persons in the United States will be a hospital patient. They will be cared for in a hospital plant which in the aggregate is valued at more than ten billion dollars. The cost of hospital care will exceed five billion dollars. This is big business. It would be big business in any league. It is certainly not big business from the standpoint of profits, but it is big business on the basis of total outlay, and on the tremendous profits it produces in good health, quick return to work, the saving of life and relief of suffering.

higher blood levels maintained longer

A totally different penicillin—not a modification of penicillin—G. Unlike all other penicillins, it has a unique chemical composition which assures stability in the presence of acid. Therefore, there is no loss of potency due to stomach acidity. 'V-Cillin' produces higher blood levels and a longer duration of high concentrations. It is rapidly absorbed from the duodenum.

dosage: 125 or 250 mg. t.i.d.

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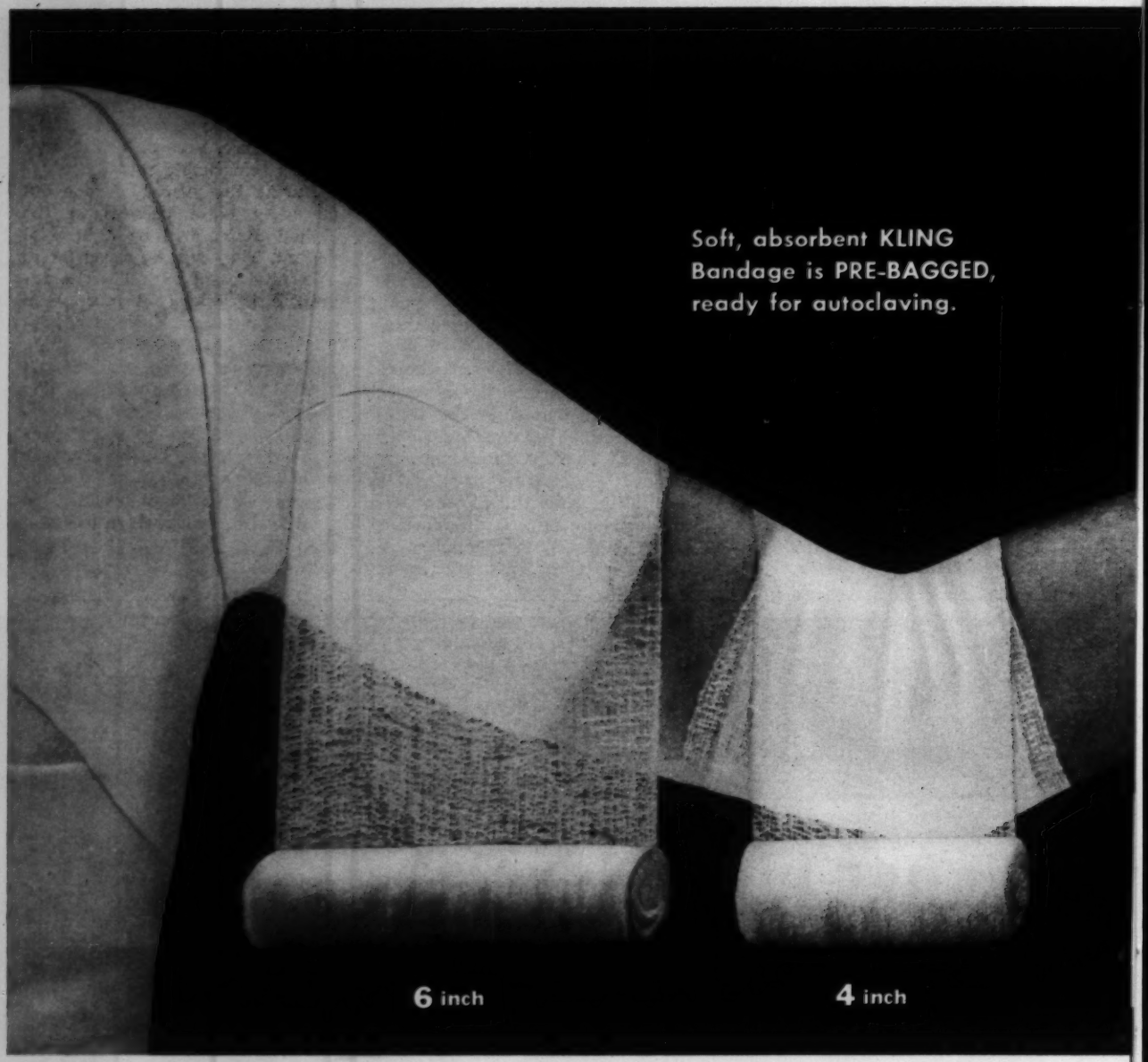

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Stretches over 40% —makes comfortable bandages that will not constrict swelling.

now in **5 convenient sizes**

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Conforms

Molds smoothly and naturally to any body contour.

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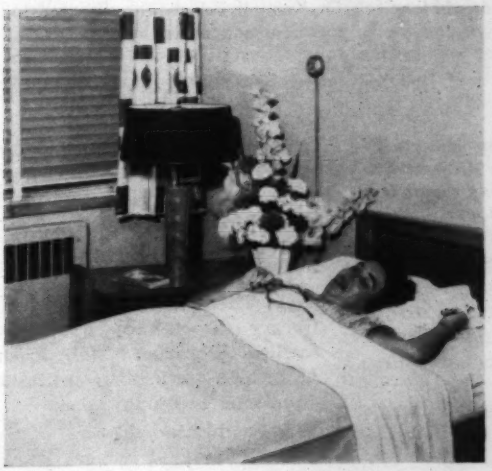
St. Luke's patients now enjoy

Individual Room Temperature Control

Milwaukee hospital modernizes by installing Honeywell Thermostat System in every patient's room



Selective room temperatures, providing for the varying therapeutic and comfort needs of the patient, are maintained by the Honeywell Thermostat System. A tiny, stainless steel molding, securely attached to the face of the plaster wall, encases and protects the small wire from the thermostat. Thus, there is no need for redecorating and the wire is not affected by scrubbing of the walls.

This is the beautiful new Honeywell Round — the thermostat chosen for use in St. Luke's. Its simple, modern styling blends perfectly with the hospital's contemporary interior. Nurses appreciate its easy-to-read, easy-to-set dial.

ANOTHER of America's up-to-date, well equipped hospitals has substantially increased patient welfare and comfort, as well as the comfort of staff members, by adding Individual Room Temperature Control.

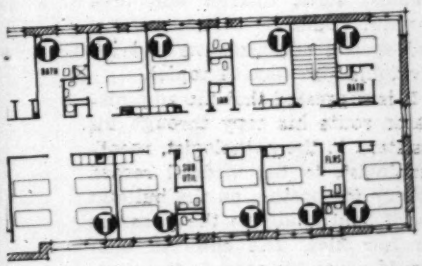
St. Luke's in Milwaukee, Wisconsin, completed and dedicated late in 1952, incorporates many of the latest developments in hospital construction. Electrically operated high-low beds can be raised and lowered by patients. And each patient room features a 2-way intercommunication system with the floor nursing station.

And now, with the addition of a Honeywell Thermostat System in each room, the *utmost* in patient comfort has been assured. Physicians and surgeons can prescribe *exactly correct* room temperatures to help speed patient recovery. And these individual room temperatures will be automatically maintained despite the varying effects of wind, sun and open windows.

If you're planning to modernize your hospital or build a new one, it will pay you to look into Individual Room Temperature Control. The Honeywell Round System used by St. Luke's can be installed at low cost in existing hospital buildings without disturbing routine. No building alterations are necessary.

For complete information on Honeywell Controls for *your* hospital, call your local Honeywell office. Or write Honeywell, Dept. HO-12-142, 351 E. Ohio Street, Chicago 11, Illinois.

Merton E. Knisely, Administrator of St. Luke's, says: "Despite our modern heating system at St. Luke's, we found that sun, wind and large window areas were resulting in underheating or overheating. The addition of a Honeywell Thermostat in each room has solved that problem. It also has made patients feel more like guests by allowing them to establish their own comfort level. Both patients and staff appreciate the added comfort provided by Individual Room Temperature Control."



Plan of a typical floor in the 177-bed hospital. T's indicate where thermostats have been placed in each room.

MINNEAPOLIS **Honeywell**

Hospital Temperature Controls

112 offices across the nation

"take it from one who knows what *Phonacall* can mean..."

Any nurse will say . . . "Phonacall saves me hundreds of steps daily . . . serves my patients faster . . . and introduces added efficiency with a completely new *plug in* system". From bedside station to nurse's control unit . . . Phonacall is entirely Faraday designed and manufactured for efficient, step saving operation and maintenance. All component parts are installed by simply plugging into wall sockets.

Save nurse's time . . . increase efficiency . . . serve patients better by installing a Faraday Phonacall system now! Write today for information.

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accreditation problems

KENNETH B. BABCOCK, M.D.

The material which follows has been prepared by the Joint Commission on Accreditation of Hospitals, Dr. Kenneth B. Babcock, director, to provide authoritative answers to questions concerning accreditation. Questions should be sent to the Joint Commission, 660 North Rush Street, Chicago 11, or to HOSPITALS for referral to Dr. Babcock and his staff.

Will a hospital be given demerits by the Joint Commission on Accreditation of Hospitals on the scoring report if it is found that nursing aides or practical nurses are being used by a hospital as the "scrub" nurse or clean nurse?

The work of a "scrub" nurse or clean nurse is considered to be mostly mechanical, and it is not necessary to use a graduate nurse in this capacity. This was proved by the armed services during the last war; they trained corpsmen or technicians to do this work, and they did a wonderful job. With the shortage of graduate nurses still critical, hospitals can alleviate the situation by training ancillary personnel to do some of the mechanics of nursing like those duties performed in operating rooms and nurseries. Never forget, however, that such persons must always be supervised by a trained graduate nurse.

Our hospital is a small one of 60 beds. Do we have to have a medical library in our own hospital? There is a big hospital a short distance away with a very complete medical library. Most of our medical staff are on the staff of the big hospital also.

Every hospital must have a medical library if it is to receive full accreditation. A library in a small hospital should have current publications (journals and magazines) pertinent to the services in that hospital. It should also have up-to-date basic standard texts on subjects pertinent to the medical care in the hospital. This latter is especially important for emergencies, day or night, when a quick look or reference is needed. A surgeon, for example, with a case of cut tendons to suture, should be able to readily refresh his mind from an anatomy or operative surgery text. It cannot be done with the library blocks away. The Standards of the Joint Commission are quite clear on this subject under CONTINGENT I D, as follows:

1. Organization.

"There shall be a medical library directed by a competent medical librarian." (In a small hospital a librarian consultant or advisor is acceptable.)

2. Facilities.

"Books and journals shall be catalogued and shall be readily accessible."

3. Personnel.

"Personnel shall be provided to assure efficient service to the medical staff."

Who receives the* Bulletin *of the Joint Commission on Accreditation?

The average mailing of the *Bulletin* is approximately 20,000 copies. Every hospital listed in the Directory Section of the Administrators Guide Issue, Part II, August HOSPITALS, the Journal of the American Hospital Association receives two copies. One is directed to the chief of staff and the other to the administrator. State and county medical societies; medical schools; state, district and area hospital councils or associations; and special organizations and individuals also receive copies.

It is suggested that the administrator route his copy through his assistant to the pathologist, roentgenologist, to the medical record library for posting on the bulletin board, and finally to the librarian for her files. The chief of staff should route his copy to the various chiefs of service and finally to the medical record librarian who can file it for future reference.

in rheumatoid arthritis

- greater therapeutic benefits
- fewer unwanted effects

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Bibliography: (1) Bunim, J. J.; Pechet, M. M., and Bollet, A. J.: J.A.M.A. *157*:311, 1955. (2) Waine, H.: Bull. Rheumat. Dis. *5*:81, 1955. (3) Toiksdorf, S., and Periman, P.: Fed. Proc. *14*:377, 1955. (4) Herzog, H. L., and others: Science *121*:176, 1955. (5) Bunim, J. J.; Black, R. L.; Bollet, A. J., and Pechet, M. M.: Ann. New York Acad. Sc. *61*:358, 1955. (6) Henderson, E.: New developments in steroid therapy of rheumatic diseases, presented at New Jersey State Medical Society Meeting, Atlantic City, New Jersey, April 17-20, 1955. (7) Boland, E. W.: California Med. *82*:65, 1955; abs., Curr. M. Digest *22*:53, 1955. (8) King, J. H., and Weimer, J. R.: A.M.A. Arch. Ophth. *54*:46, 1955. (9) Criep, L. H.: Prednisolone and prednisone in the treatment of allergic diseases, to be published. (10) Sternberg, T. H., and Newcomer, V. D.: Am. Pract. & Digest Treat. *6*:1102, 1955. (11) Gordon, D. M.: Prednisone and prednisolone in ocular disease, to be published.

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*T. M.

ML-J-55

● *1,000,000 NEWSWEEK* families will better appreciate the Radiologist *as a physician* after reading this message in the December 12 issue. Reprints of each advertisement in this series are available.

once upon a time, mama had TB . . .

but that was long ago — a fading memory. She's a happy mother now, leading a healthy, normal life; not the semi-invalid she expected to be — way back when she was eighteen and had TB.

It all started with a tonsillectomy. That's what brought her to the hospital. Then her personal world came tumbling down, when the radiologist spotted a telltale shadow on the chest x-ray film taken as a part of the routine entrance examination. Medically speaking, it was a tiny lesion—tuberculosis in its earliest stages — but to her, it was the final tragedy. Like many people, she thought of TB as the all-powerful killer that couldn't be denied.

At the sanitarium her outlook changed . . . she saw a different picture. There, she learned first-hand of the medical profession's great progress in combatting tuberculosis. There, in a calm, relaxed environment, hope for the future revived. In less than a year, the TB was arrested . . . *and she's living happily ever after.*

This young mother's case illustrates the "happy endings" made possible by early x-ray detection and prompt treatment of tuberculosis. Through the development of ever-better x-ray apparatus, General Electric implements the important work of the skilled, medically trained x-ray specialists—the radiologists who have done so much to uncover TB.

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SQUARE	*more capacity*	FOR • *Wrapped Instruments*
FAST	*when seconds count*	• *3-Minute Emergency*
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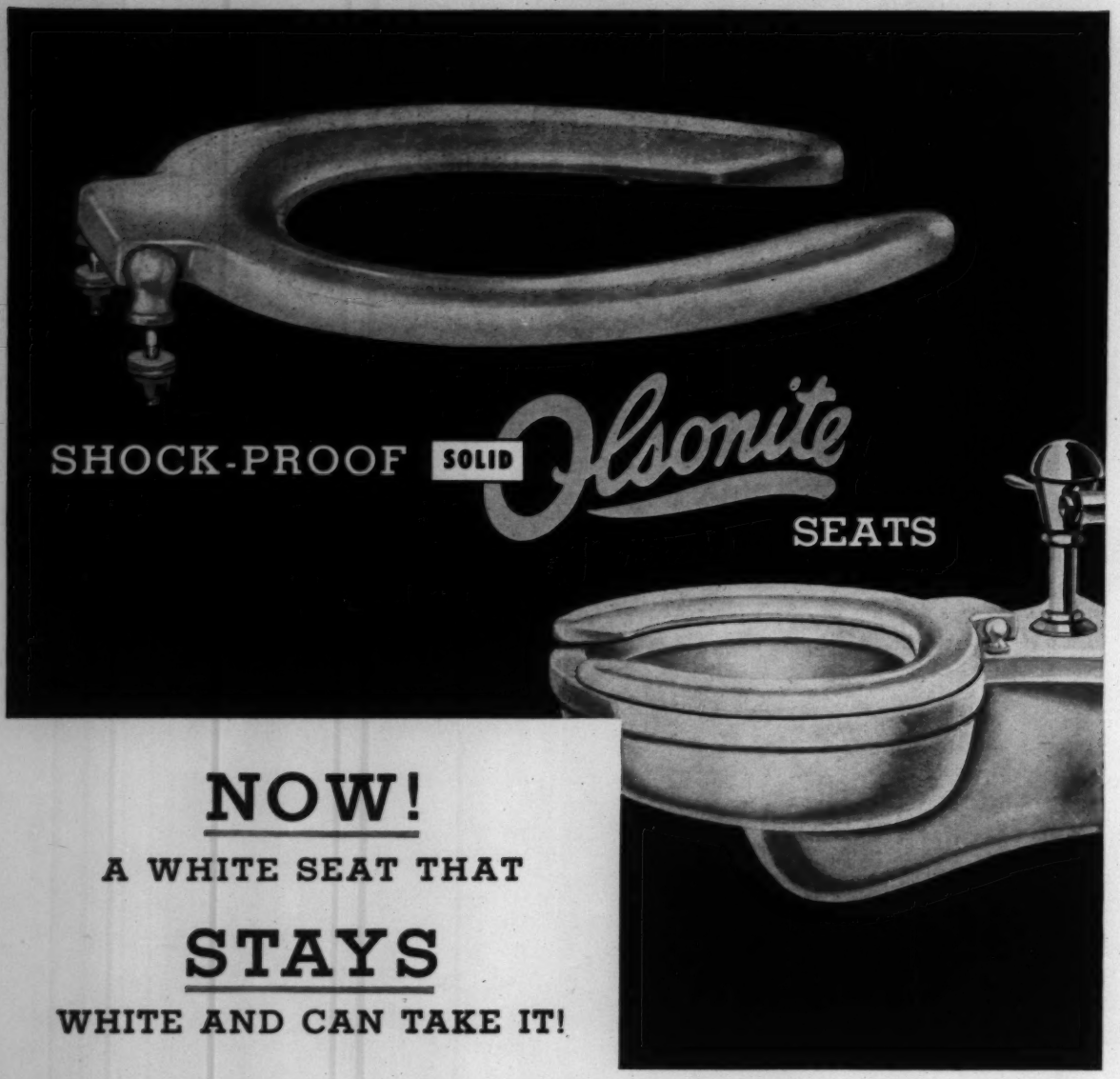

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WHITE AND CAN TAKE IT!

White seats look more sanitary, are easier to *keep* sanitary. Now you can install white seats for all installations—white seats that won't "yellow" for a lifetime of normal use!

With the new Olsonite White Shock-Proof Seats, it's easier to keep that clean, sanitary appearance than with black seats. Shock-Proof Olsonite Seats have also proven their ability to withstand shocks 5 times greater than ordinary solid one-piece seats. Deliberate abuse won't crack, chip or break Olsonite Shock-Proof Seats—and they won't absorb water. When installed, there is no exposed metal to rust or corrode.

Like all Olsonite Seats, Shock-Proof models are solid one-piece construction—there is no applied finish to crack or peel. They are sanitary white *all the way through*. Be sure to install the seat that *stays white*—the seat that can "take it" without damage for a lifetime of normal use—Solid Olsonite Shock-Proof Seats.

Olsonite Shock-Proof Models Are Available in White or Black

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Plastics Division
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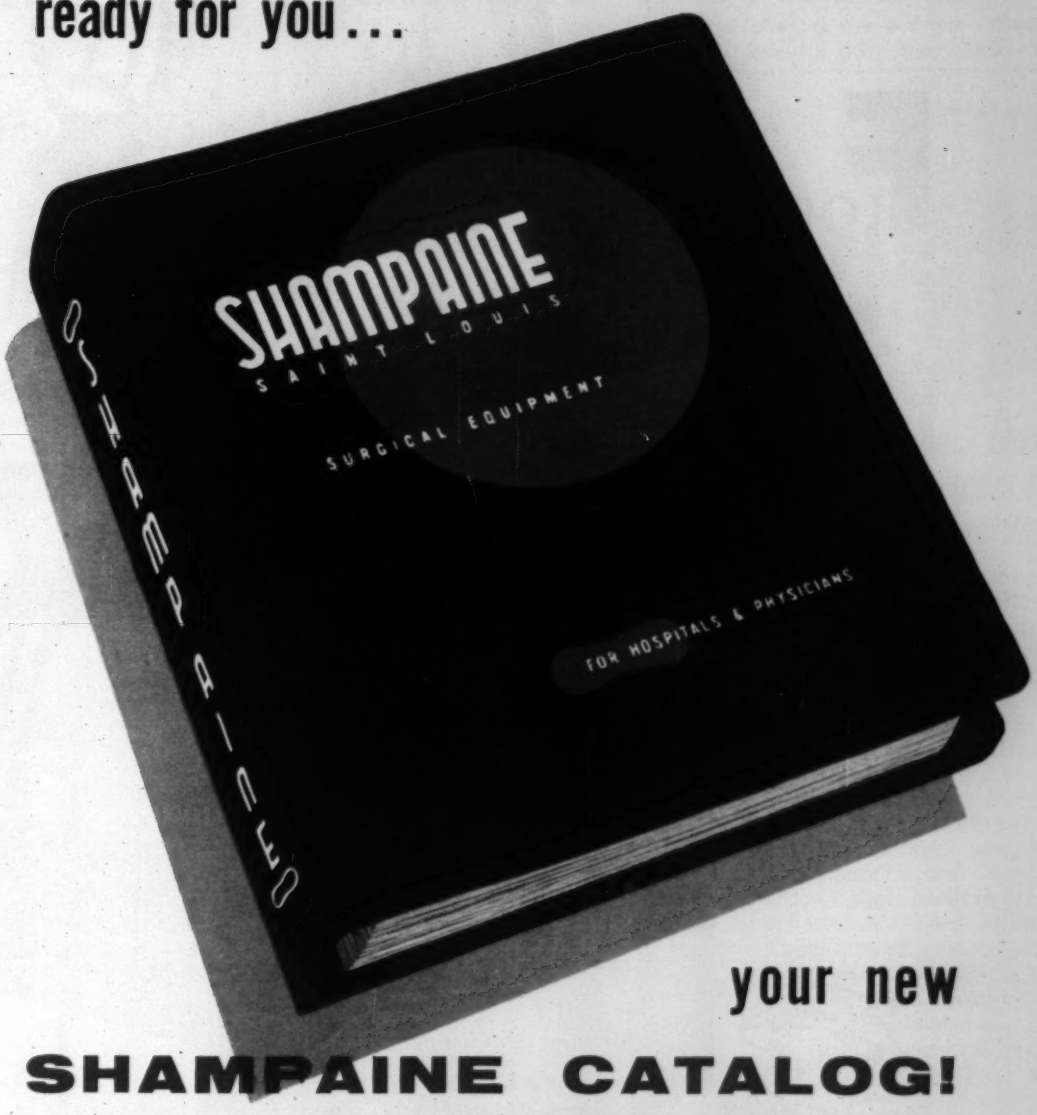

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Why Hospitals Are Using Mechanical Card Filing For The Master Patient Index

More and more hospitals throughout the country are finding it pays to use Remington Rand Convé-Filer for the Master Patient Index because of big savings in reference time, clerical costs and filing efficiency. The operator remains comfortably seated. Just the touch of the toe on a foot pedal (or the finger on a push-button selector) and the tray containing any one of 200,000 cards is positioned electrically at convenient, efficient desk height. Convé-Filer is outstanding as the most efficient equipment yet developed for a large active card file. Exhaustive tests made by methods analysts show that savings to be obtained with Convé-Filer more than justify its original cost... savings of 30% on clerical cost alone. Get full particulars. Circle LBV160 on the coupon.

New, Compact Model 8 Camera – Ideal for Hospital Microfilming

The Remington Rand Film-a-record, Model 8 Microfilm Camera combines big machine performance with portability and economy. Requires no more space than a typewriter yet produces the finest, most accurate microfilm results. With microfilm, your hospital can quickly and economically modernize its record filing and retention system to conserve space, time and energy. Your case histories and hospital records on film conserve up to 94% of original-record filing space. Thousands of square feet of valuable hospital floor space can be immediately reclaimed for scientific and medical use.

Call Remington Rand for a free analysis of your hospital record-handling procedures.

Circle F383 on the coupon.

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The new manual, "Purchasing Procedures That Save Time and Money," can be your guide to more efficient buying. These new purchasing procedures tell you in an instant whether specifications are complete, whether hospital-wide needs have been anticipated, and how much an order can be increased or decreased.

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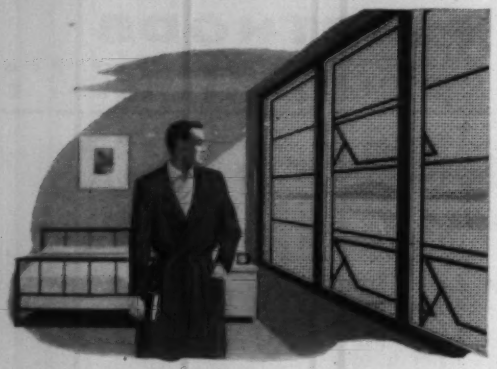

THESE WINDOWS CREATE A HEALTHFUL, HOMELIKE ATMOSPHERE

There's no "barred look" with these Fenestra* Psychiatric Package Window Units

In the attractive appearance of these modern, awning-type windows in Kansas City's new Psychiatric Receiving Hospital, there is nothing to suggest restraint. The needed protection is in the window's design, and in its covering screen.

Besides the steel window itself, the Fenestra Psychiatric Package Window unit includes steel casings, operating hardware (bronze adjuster handle is removable), and the choice of three specialized, flush-mounted, inside screens. (1) A *Detention Screen* gives maximum restraint. The finest stainless steel mesh is attached to strong, concealed shock absorbers. (2) A *Protection Screen,* without shock absorbers, is used for less disturbed patients. (3) An *Insect Screen* is used for windows in nonrestraint areas. All three screens, of course, serve as insect screens.

This window has no projecting parts to encourage climbing. There are no sharp corners. The patient can't get at the glass. All-weather ventilation is controlled without touching the screen. Window is washed inside and out, from within the room.

To eliminate maintenance painting, Fenestra windows are available Super Hot-Dip Galvanized, from America's only plant specifically designed for hot-dip galvanizing of steel windows. For complete details, call your Fenestra Representative, listed in the yellow pages of your classified telephone directory, or write Detroit Steel Products Co., Dept. H-12, 2292 East Grand Blvd., Detroit 11, Michigan. *®

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Architectural, Residential and Industrial Windows
Metal Building Panels • Electrifloor* • Roof Deck
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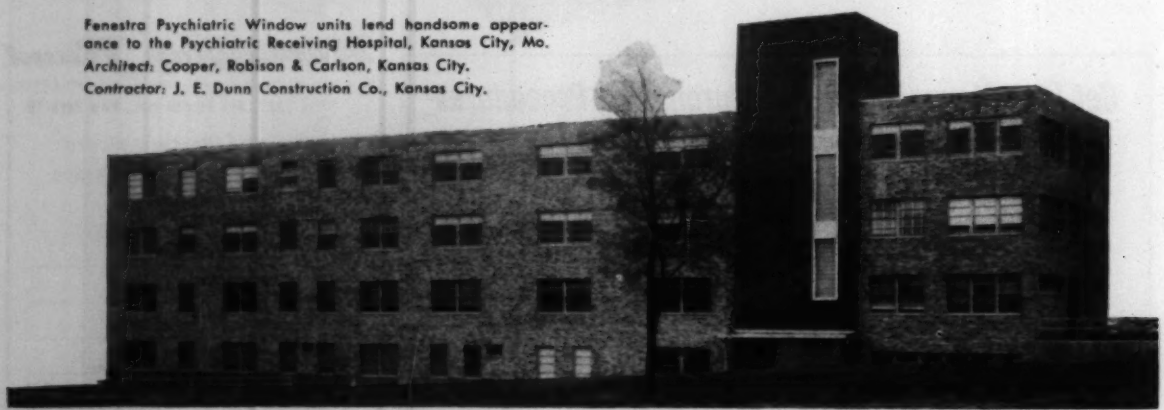
Fenestra Psychiatric Window units lend handsome appearance to the Psychiatric Receiving Hospital, Kansas City, Mo.
Architect: Cooper, Robison & Carlson, Kansas City.
Contractor: J. E. Dunn Construction Co., Kansas City.



1. Testing raw materials

2. Testing gas during processing

3. Testing contents of each individual cylinder

specify
OHIO MEDICAL GASES

- Cyclopropane
- Nitrous Oxide
- Ethylene
- Oxygen
- Helium
- Carbon Dioxide
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- Helium-Oxygen
- Ethyl Chloride
- Trimar
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The Ohio label on the blue cylinder of nitrous oxide is your assurance that it is *triple-tested* — setting standards that exceed U.S.P. requirements.

Cylinders are inspected, cleaned, and reconditioned before filling and then sealed against dust and tampering. Nylon valve seats insure safe, dependable operation, and Teflon washers provide easy-opening, self-sealing protection against leakage.

Prompt, dependable delivery from a nationwide network of over 500 Ohio branches and authorized dealers.

You can place your confidence in Ohio Nitrous Oxide — triple-tested for quality.

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Airco Company International, New York 17
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AT THE HANDSOME, MODERN NEW FAYETTE COUNTY HOSPITAL, VANDALIA, ILLINOIS

Everything in and about the new Fayette County Hospital is efficient, neat, orderly and pleasant. Located in a quiet residential neighborhood, with grounds superbly landscaped, this modern hospital has gone to great lengths to provide the ultimate in care and comfort for its patients and personnel.

Like countless other fine institutions, the Fayette County Hospital has provided Ivory Soap for the personal cleansing needs of those within its walls. Again, a fine soap is chosen to serve a fine hospital.

MORE DOCTORS ADVISE IVORY THAN ANY OTHER SOAP!

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CONDUCTIVE FLOORS, IMPROPERLY MAINTAINED

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insist upon a conductive wax bearing this seal . . .

Static electricity *strikes* without warning. The installation of conductive floors in the operating suite is one answer to your safety problem . . . but only part of it. They must be maintained properly with safe cleaners and waxes to retain their conductivity and safety factor!

All conventional waxes and finishes are insulators which immediately decrease conductivity and enhance the possibility of an explosion. Yet the floor must be waxed because unfinished, it often has unsatisfactory gloss, is hard to clean and wears out too soon. Only an *accepted* conductive wax should ever be applied to conductive floors!

There are *only* two waxes that bear the Underwriters' Label on the basis of safe electrical conductivity . . . these are Huntington's VC-2C (clear) and H-22 (black) Conductive Waxes! They are water-based waxes and produce a durable, water-resistant surface that may be polished to a high luster.

Tell us the type and color of conductive floors you have and we'll see that you receive samples of the correct Wax for your use. There's no obligation. Write your request to Huntington Laboratories, Inc., Huntington, Indiana, today!

Here's the complete package for safety! Maintenance of conductive floors in operating suites *must be handled differently* . . . let us show you how!

HUNTINGTON

CONDUCTIVE WAXES

with SPAL Concentrate Detergent

service from headquarters

Microfilming medical records

What is the opinion of the American Hospital Association regarding microfilming of medical records?

Microfilming is used by a number of hospitals. It is possible by such means to reduce the amount of space required to about 1 per cent of that needed for storing records in their original form. Space saved will depend on the way in which the microfilmed records are filed, the maximum saving being effected when it is filed in uncut rolls that carry a large number of medical records per roll. The space saving is less when one of the card forms for filing the individual microfilmed record is used.

Microfilming has legal acceptance in most areas, although you may wish to check with your attorney concerning your local situation. It is usually best not to attempt to microfilm records that are currently in active use, but to microfilm first records of patients who are now dead, or records that have been inactive for a period of time and are not likely to become active again.—SARAH H. HARDWICKE, M.D.

Workmen's compensation

We have been told that some hospitals do not include student nurses as employees and therefore have no coverage for them under workmen's compensation laws. Our student nurses pay tuition and attend classes. They are paid no compensation and are furnished full maintenance, including health service. Can you advise whether or not under such circumstances our students should be included under workmen's compensation coverage?

The advantage of including student nurses in this form of insurance is that whatever injury the student sustains, the compensation for it is pretty well determined in advance. If, however, students are not included in this insurance, and one is injured somehow through the corporate negligence of the hospital, the damages eventually awarded are at the discretion of a jury.

Because the compensation of students is comparatively small (furnishing maintenance can be interpreted as compensation), the cost of this insurance is low, provided that the hospital does not expect the insurance company to reimburse it for ordinary health and first aid services.—WILLIAM T. ROBINSON.

Handling contaminated linen

What is the proper way to handle contaminated linen?

The American Hospital Association's *Hospital Laundry Manual of Operation* contains an excellent discussion of this problem on page 102.

The basic problem in handling known contaminated linen lies in devising a system whereby no one need touch the linen after it leaves the isolation ward. By adopting the following procedures, such a system can be accomplished:

(1) Have all sorting done by nurses, or by auxiliary personel under the supervision of nurses, on the isolation wards or other areas.

(2) Have nurses, or auxiliary personnel under the supervision of nurses, place the sorted articles in mesh bag containers in which the articles remain throughout the laundry processes up to the final ironing.

(3) Place the mesh bags in special laundry baskets or cans. The baskets have a large removable canvas lining with covers that can be tied down and the cans are canvas lined with a metal lid. The covers are marked to give notice that the contents are contaminated. Isolation techniques are followed in loading these baskets and cans so that the areas outside the canvas containers are uncontaminated.

(4) With the baskets free of contamination, the truckmen can transport them to the laundry without danger.

(5) Have the specially marked baskets and cans segregated in the laundry and handled in one operation.

(6) Instruct the person responsible for loading the washer to: (a) open the canvas cover on the basket and remove the lid from the can; (b) pick up each mesh bag with a pair of tongs without touching anything en route; (c) treat the load as any other once the washer is loaded; (d) deposit the empty canvas bags into a washer designated for colored garments using tongs, (e) sterilize the tongs for further use.

With this procedure, only the laundry man who loads the washer has any possibility of direct contact with the contaminated linen. Carelessness on his part could endanger him and others.

This individual should be immunized against the common disease, be instructed as to the reasons for special care on his part and be checked on periodically through surprise inspections to see that he is following established procedures.

Certainly caution is to be exercised by everyone, but we must recognize that this is a matter of continuous education for all personnel concerned.—JOSEPH A. WILLIAMSON.

Hospital policies

What suggestions can you give us for preparing a policy manual?

In gathering material on procedures, policies, rules and regulations for your policy manual, it is well to bring department heads in to the fullest extent. Having each department head describe his departmental outline of objectives, policies, organizational relation-

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

Controls of the Troy Fullmatic Washer. Operation is fully automatic, even adding of supplies.

In a few seconds, the operator slides the load out from the labor-saving "Slyde-Out" Shelf.

SELECT FROM

101 Different Washers

You're sure to find the right one for your laundry. The complete line of Troy washers not only includes a broad range of types and capacities . . . but offers these with a choice of controls and other labor-saving devices. Possible combinations amount to 101 — actually 101 different washers. Consult the chart below as a guide to which washer and what features best fit the requirements of your laundry. Then fill out the coupon and mail it today for complete data.

	FULLMATIC® WASHER	ELECTROMATIC WASHER	ELECTROMANUAL WASHER	LAUNDRITE WASHER
CAPACITIES (in pounds)	150, 225, 350, 400	60, 95, 150, 225, 350, 400		25, 40
CONTROLS	Semi-automatic. Fully automatic.	Simplified semi-automatic.	Manual, with easy-to-operate controls.	Automatic or semi-automatic.
UNLOADING TYPES	"Slyde-Out"® Shelf, Removable Partition or Open Pocket			Open End

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Without obligation, please send me full data on the washers and features I have indicated.

WASHER NAME

CAPACITY

CONTROLS

UNLOADING TYPE

ORGANIZATION

ADDRESS

CITY ZONE STATE

NAME AND TITLE

ships and procedures is invaluable. Once key persons have had an opportunity to participate in a task such as this, the completed manual will be better received and followed.

One of the most comprehensive manuals on policy is the administrative manual of St. Mary's Hospital, Rochester, published by the Catholic Hospital Association. Copies may be purchased from the Catholic Hospital Association, St. Louis 4, Missouri.—ANN S. FRIEND.

Election of delegates

What is the procedure for election of delegates and alternates to the American Hospital Association?

Every two years states and provinces are notified to elect delegates and alternates to the House of Delegates. Provisions for conducting elections are contained in Article X of our Bylaws.

Briefly, this is the procedure. In affiliated states, the state hospital organizations are asked to conduct this election in accordance with their usual practice. Institutional members, except Type V, vote in these state elections.

In states that are not affiliated, the president of the AHA appoints a committee of three to conduct the elections among the AHA members in that state or province.

When the AHA is notified that a delegate or alternate has moved from a state, it notifies the affiliated state hospital association and suggests:

(1) Election of a replacement for the delegate if a general meeting of the membership is to be held prior to our annual convention.

(2) Appointment of a replacement by the board of trustees of the state organization, if a general meeting of the membership is not to be held before our annual convention.

In the latter instance, the recommendation of the board of trustees of the state association is forwarded to the Board of Trustees of the American Hospital Association for certification and is in turn reported to the House of Delegates for ratification at its first session. —HOWARD F. COOK.

Charges for late admissions

What policy do most hospitals follow regarding room charges for patients who are admitted shortly before midnight? Our policy is to charge for the first day and not for the last.

Many hospitals follow the policy of charging for the day of admission but not for the day of discharge. If a patient is admitted to the hospital shortly before midnight, this policy should be flexible enough to be applied practically to individual situations. We have no statistics on a cut-off hour such as 11:00 p.m. for determining whether a charge will be made for the day of admission.—RONALD A. JYDSTRUP.

Records for long-term patients

What is the method used for working out patient days on a discharge basis, specifically in reference to patients in the hospital for a long period?

The *Handbook on Accounting, Statistics and Business Office Procedures for Hospitals*, published by the American Hospital Association in 1950, includes a section on computation of patient days of service rendered to each inpatient during

Now... SNAP-OUT Lab Slips
WITH PRESS-ON GUMMING

- Forms Available in Duplicate or Triplicate
- Special Pressure-Sensitive Adhesive on Back
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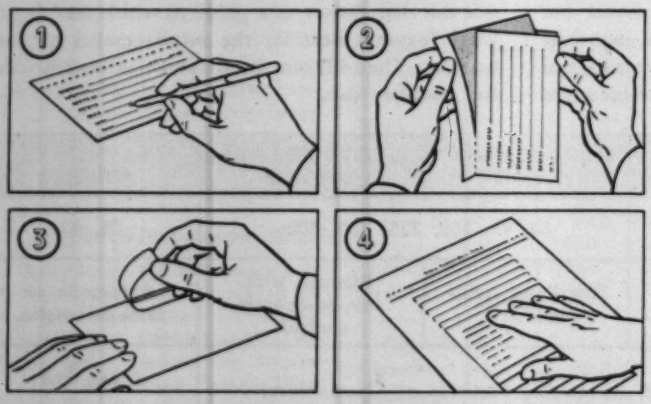

Now you can really save time when completing laboratory slips. These snap-out slips have the carbon preinserted for duplicate and triplicate copies. Simply (1) record the data, (2) snap out the copies, (3) peel off the protective covering on the back of the original copy, and (4) press the slip on to the master report . . . all in a matter of seconds. No water, no wiping, no waiting for anything to dry — *simply snap out, peel and press.* Slips are 3" x 5", and there are 18 different types of slips available.

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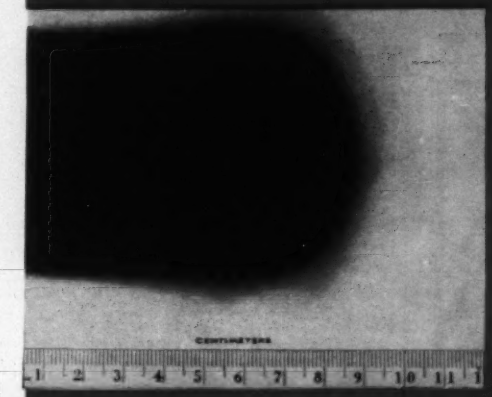
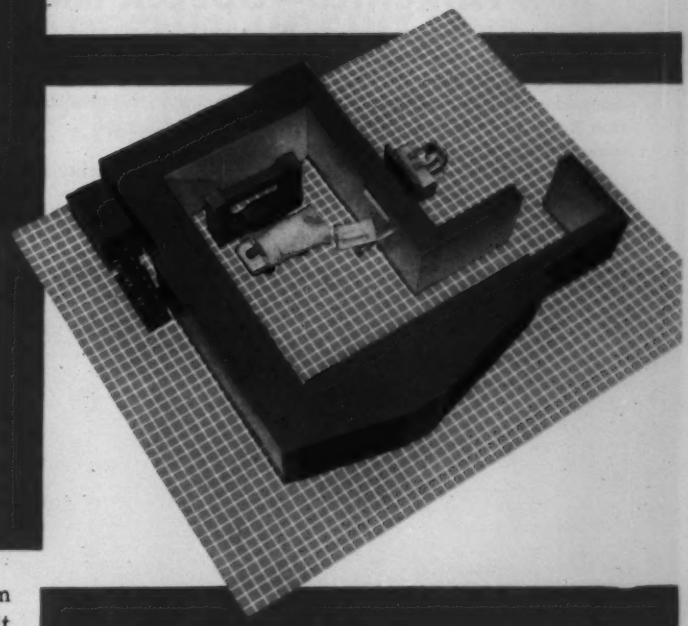
Electron Beam Therapy

Exposed film shows effect of Allis-Chalmers 24-mv betatron when equipped with tube for electron beam therapy instead of X-ray tube. Absorption is more homogeneous. Effective depth can be regulated with voltage. And the difference between absorption in bone and soft tissue is less than with conventional roentgen rays.





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●Initial results show that electron beam therapy with Allis-Chalmers 24-megavolt betatron may be ideal for lesions exceeding 3 cm in thickness, as deep as 8 cm. Even though the number of patients treated has been low, curative effects reported have been impressive. Since the electron beam is distributed homogeneously throughout the tumor, treatment is fast, yet gradual and even.

Exit dose is insignificant beneath the lesion in healthy tissue. There is less risk of skin erythemia and faster recovery from radiation reaction due to the dosage distribution than with other methods of radiation treatment.

The biological factor of the high energy electron beam on the skin, mucosa, and tumor is 0.70. An electron beam dose of about 8,600 r is equivalent to about 6,000 r of 400-kv radiation.

If you would like more information on electron beam therapy, write to Allis-Chalmers, Milwaukee 1, Wisconsin. Or consult the A-C office nearest you to arrange a call by an experienced betatron engineer. A-4788

ALLIS-CHALMERS

a given period. This section points out that where the average stay is long or greater than the period under consideration, the usual formula—total patient days during the period divided by the number of discharges during the period—may be inaccurate.

Obviously, the mathematically correct way of figuring average stay is to take the actual number of patient days care given to each of the group of discharge patients and divide this by the number of patients in the group. As the *Handbook* points out, this is the method recommended for hospitals with patients who stay for a long period of time.—SARAH H. HARDWICKE, M.D.

Linen cost per patient day

What is the average cost of linens per patient day in a general hospital?

An average of about 12 pounds of linen per patient day is used in hospitals. By multiplying that by 5½ cents per pound—the average cost per pound of laundry processed—we arrive at a figure of approximately 66 cents per patient per day. Allowing for certain variables—such as processing laundry commercially—the per pound cost may be somewhat higher. An accurate estimate of the cost of linen per patient per day would be from 65 cents to 70 cents.—JOSEPH A. WILLIAMSON.

Hospital road signs

Three of the hospitals in our city have signs posted on the highways leading into the city. We are interested to know if this is a violation of the Code of Ethics of the American Hospital Association. Would there be any objections to posting signs leading into the city with the wording "serving the community for over 40 years?"

Placing a road sign reading "Hospital" or "Memorial Hospital" on the major arteries leading into your town could be a service to the general public in locating your institution rapidly in case of an emergency. It might save vital time in emergencies, especially for those who are not residents of your area.

The Code of Ethics approved and adopted by the American Hospital Association and the American College of Hospital Administrators states, "information relative to the activities of a hospital should not be designed to secure comparative advantage over other hospitals or personal aggrandizement of any individual." The Code further states, "there should be no solicitation for patients by a hospital or by any person connected with it."

"Telling Your Hospital's Story," published by the AHA, states, "It is often most difficult to draw a fine line between a statement of fact and a boast. Perhaps intent is about the best criterion. If you can honestly say that in your advertisement you've sincerely avoided any suggestion that your hospital is better than others—that would imply an attempt to woo patients to your institution—then chances are good that it is ethically satisfactory."—HOWARD F. COOK.

Appointment of osteopaths

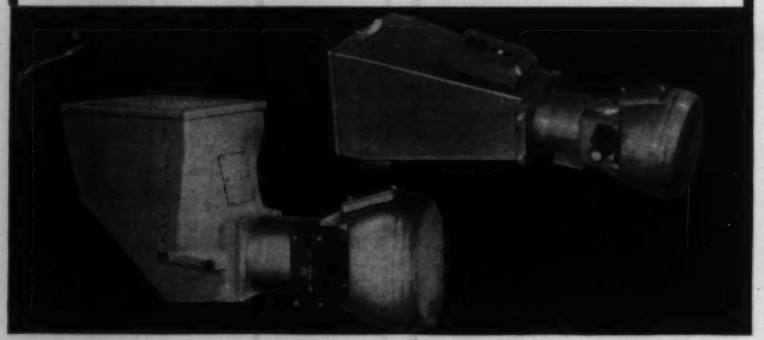
What is the position of the American Hospital Association in regard to appointment of osteopaths to the hospital staff?

The right to grant privileges to physicians is vested entirely in the

Major advances in high-speed photofluorography offered by new FAIRCHILD—ODELCA line

Two new models in the versatile Fairchild-Odelca line of super-speed 70 mm. photofluorographic cameras – the X-70SA Angle Hood and the X-70S In Line Model – cover applications in the four major categories of photofluorography; mass chest survey... hospital admission X-ray (supine and ambulatory) . . . serial radiography . . . and some aspects of general radiography.

These cameras produce unequalled high diagnostic quality negatives at lower cost and with ¼ the exposure time required by other cameras now in use. The extensive X-ray experience of Fairchild and Odelca has produced some outstanding features:



• **SHORTER EXPOSURE TIME** — High working aperture of f/0.8 (GRA f/0.63) permits much lower tube current and 75% less exposure time resulting in substantially reduced radiation.

• **VIRTUAL ELIMINATION OF RETAKES** — Stops voluntary and involuntary motion, yet provides diagnostic information comparable to full size radiographs.

• **VERSATILITY**—Efficient for both diagnostic and mass survey applications.

• **SHARPNESS OF DETAIL**—Approximately four times increase in resolution.

• **AUTOMATIC SAFETY DEVICES** — The apparatus interlocks against exposure unless all operating sequences are performed.

• **FOOLPROOF IDENTIFICATION** — Data on patient's card is reproduced on lower edge of negative.

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X-RAY EQUIPMENT AND ACCESSORIES

For complete information, contact your local X-ray equipment supplier or Fairchild Camera and Instrument Corporation, Syosset, N. Y., Dept. 160-42Q1.

Mechanized laundry department, 219-bed Children's Hospital, San Francisco, Calif. Left to right, 42" x 96" and 42" x 84" Cascade Unloading Washers with full-automatic controls. 42" x 36" Cascade Washer, 54" Notrux Extractor and five 36" x 30" Zone-Air Drying Tumblers.

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When Children's Hospital, San Francisco, modernized its laundry department by installing automatic American equipment, they netted savings of nearly $14,000.00 a year in labor costs alone. Now over 3½ tons of work are washed, dried and finished daily, *with six fewer operators.*

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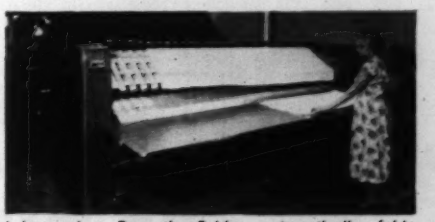

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board of trustees of the hospital. The decision to grant permission to an osteopathic physician to practice or allow his patients to use the facilities in the hospital is therefore vested in the board of trustees.

The Association believes that the best medical care to patients will result when medical care is given only by medical practitioners. Consequently, the standards of medical practice required of hospitals which are members of the American Hospital Association is that the medical staff shall be composed of doctors of medicine graduated from recognized medical schools, licensed to practice in the state and of good moral character. The schools of medicine recognized by the AHA do not include osteopathic schools or schools that train other types of practitioners of the healing arts.

Departures from this standard by a hospital, when brought to the attention of the Association, will result in cancellation of membership and removal from the Association's list of acceptable hospitals.
—SARAH H. HARDWICKE, M.D.

Cost of community surveys

A joint committee of top business leaders in our community has been established to obtain funds for a detailed survey to serve as a "master health plan" for long range planning. What is the cost of such a survey?

It is difficult to predict the cost of a community hospital survey without being on the scene. The cost would relate directly to the scope and type of survey desired.

The approach to undertaking a survey is extremely important. Steps to follow are: bring together the health leaders of the community—especially the local hospital council if one exists—to coördinate existing facts and viewpoints; contact the director of your state hospital facilities program regarding planning on a statewide and community basis; and obtain the services of an experienced hospital consultant.

A directory of the American Association of Hospital Consultants, available on request from the American Hospital Association, will prove helpful in contacting consultants. It would be normal procedure to discuss the survey with several consultants before deciding upon final arrangements.

The type of survey required and the extent of the consultant's services would determine the cost
—CLIFFORD WOLFE.

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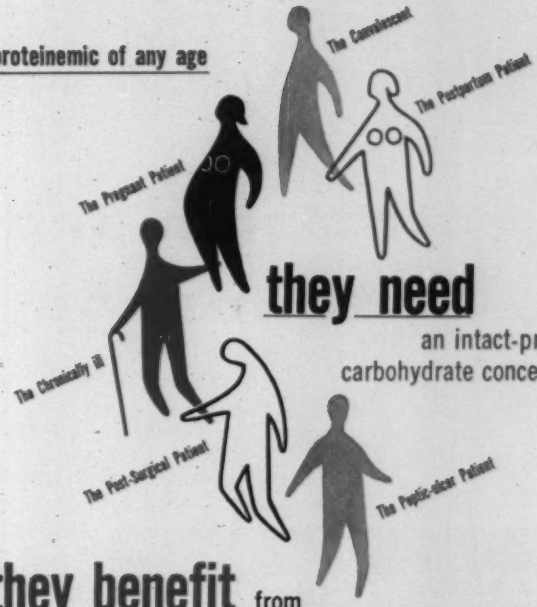

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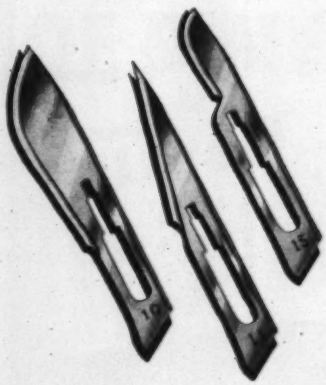

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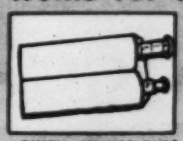

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HOSPITALS
JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

editorial notes...

—accreditation study

A special committee of the American Medical Association has undertaken, at the request of its House of Delegates, a study of the accreditation program.

It is hoped that the report this committee will make will dispel the misconceptions some physicians have concerning accreditation. These misconceptions are based, we believe, on a lack of full understanding of the program.

December 6 marks only the third anniversary of the formal conveyance of the hospital accreditation program from the American College of Surgeons to the Joint Commission. In this short time, the Commission has made remarkable progress. Continued success is dependent upon acceptance of the voluntary program by those most concerned, physicians and hospitals. Such acceptance will be in direct ratio to the measure of the understanding of the program.

We are confident that this understanding on the part of physicians will be increased by the work of this special AMA Committee. The study group is now seeking the help of hospitals. It would like to have comments on the accreditation program from hospital trustees and administrators. These comments should be sent to the chairman of the committee, Wendel C. Stover, M.D., at the AMA, 535 North Dearborn St., Chicago.

We urge all hospitals to coöperate with this committee in its important task.

—party of the third part

Hospitals can't balance their budgets unless they receive costs for services rendered. Increases in direct charges to patients produce ever diminishing returns because the number affected by such charges is decreasing steadily. Realistic hospital financing is not possible, therefore, without realistic payments from third party agencies.

Government has been the worst offender in the matter of unrealistic payment for hospital care. The picture has brightened in the past several years but there are still many dark spots. In New York City, for example, the payment was increased a year ago. All the increase did was narrow the differential between the cost and what the city was willing to pay. Apparently, arguments that payments and costs should be related were shrugged off.

Another example has just come from Mississippi. In preparation for the forthcoming session of the legislature, the state hospital association has collected some data on payment for indigent care.

From July 1, 1954, to June 30, 1955, 87 hospitals participating in the indigent care program rendered 108,621 days of care for 12,192 charity patients. The state paid $5.54 per patient day for care which cost $16.51 to give. The total loss to the participating hospitals was $1,189,988. Per patient, the loss was $97.61. The Association bulletin urges administrators to bring these figures to the attention of the legislators and to ask "why the state is willing to bear only 33% of the cost to safeguard the health of its citizens. Remind them that the state expects to and never quibbles over paying full cost plus a profit to the dealer on automobiles, coal, etc."

The hospitals, of course, don't want a profit on the indigent patient. They simply want fair play.

—ground is broken

Ground was broken last month for the American Hospital Association Headquarters and Center for Hospital Affairs.

It was more than just a ceremony. It marked the physical beginning of what we believe will be a new and even greater chapter in the affairs of the Association and its membership.

The building will provide a home befitting the dignity and importance of the Association and allied organizations. It will also provide the facilities necessary so that the Association can provide the needed expansion of its services to the membership.

—Dr. Low-Beer's contribution

This issue of HOSPITALS, the Journal of the American Hospital Association, contains a paper on the use and handling of radioactive isotopes by Dr. Bertram V. A. Low-Beer.

The paper is published posthumously, Dr. Low-Beer having died last September in California.

As a member of the AHA's Committee on Use of Radioisotopes in Hospitals, Dr. Low-Beer contributed substantially to our knowledge of hospital use of radioactive material. He worked hard on this problem until no longer able to do so because of the illness which led to his death.

In a letter of condolence to the noted radiologist's widow, President Ray Brown said:

"The medical and hospital field has lost one of the most able men in the entire health scene. It was my pleasure to work with Dr. Low-Beer as a member of the Committee on Use of Radioisotopes in Hospitals. During that relationship I became an admirer of his. His judgment, his vast knowledge and his willingness to carry more than his own share of the load were very evident characteristics."

—incident reports

There is more to a liability insurance program, or there should be, than simply accepting the contract and paying the premiums. The administrator who thinks that that's all there is to it may wake up one morning to find his rates hiked beyond reach or, even worse, find his hospital uninsurable.

Part of the insurance package must be a program to prevent the incidents which produce claims. This will benefit the patient directly by enhancing his safety. This will benefit the hospital directly by reducing the claims which bring settlements or damage verdicts and, in their wake, higher insurance premiums.

An effective safety program cannot be built on generalities. It must be built on specific knowledge, the knowledge which can be gained only from a regular system of reporting and studying special incidents in the hospital.

In California, a coöperative insurance project has been established. One of its integral elements is collection and analysis of incident reports from all participating hospitals. A preliminary study of these reports is published in this issue (p. 68) of HOSPITALS, the Journal of the American Hospital Association.

It provides necessary information on which a sound safety program can be based, one aimed at preventing all incidents which could result in injury to the patient. The report is not limited to those incidents which produced claims. Whether or not a claim results is secondary. The primary purpose is to prevent the incident. If we do this, we shall also prevent the claims.

—our last monthly number

This is No. 12, Vol. 29, of HOSPITALS, the Journal of the American Hospital Association. It is our last issue as a monthly publication.

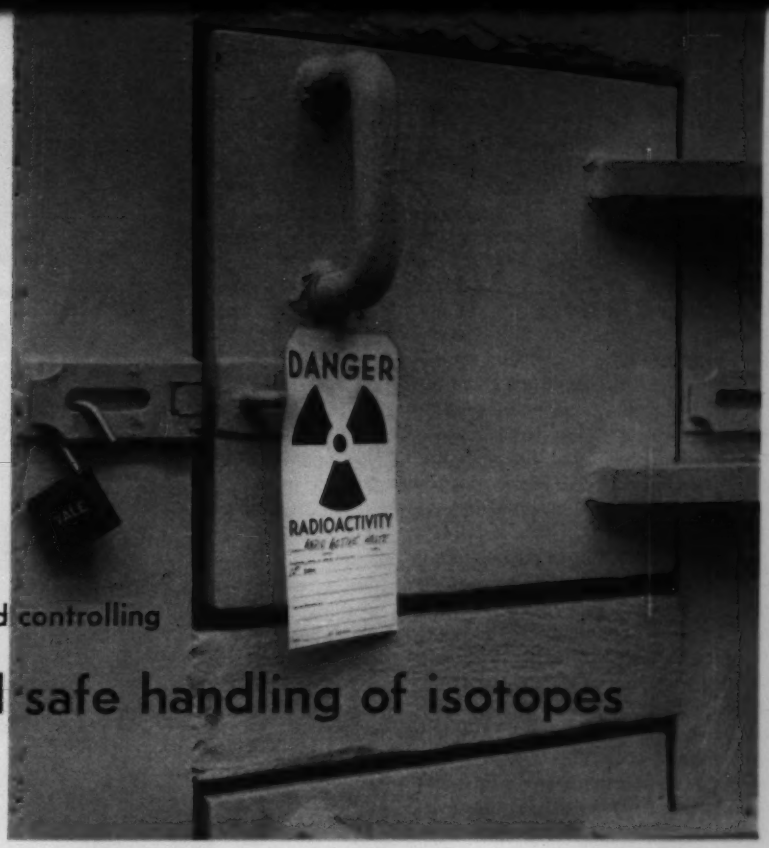
Beginning January 1, the Association's Journal will be published twice each month, on the first and sixteenth. The decision was made in order to provide a more timely journal in an easier-to-read package for the busy administrator. We believe it will also expedite its circulation to department heads concerned with one or another specific article. The cover is also being changed (although the "Association blue" is retained).

It is our earnest hope that the changes will increase the service of our Journal to the membership.

to all –

Season's Greetings

from the Officers,
Board of Trustees and Staff



organizing and controlling

the use and safe handling of isotopes

BERTRAM V. A. LOW-BEER, M.D.

THE DEMAND FOR radioisotopes service in general hospitals is increasing daily. Radioisotopes are no longer considered as mere research tools, but rather as an integral part of medical practice. The diagnostic and therapeutic values of some of the radioisotopes are so well established that patients expect and physicians urge that facilities for the use of radioisotopes be made available not only in large hospitals, but in hospitals in smaller communities as well. This expanding use of radioisotopes is well documented by the yearly increase in radioisotope shipments from the Oak Ridge National Laboratories, from some 200 shipments in 1946 to almost 11,000 in 1953.

Of the several hundred artificially produced radioisotopes, only a few have so far attained clinical significance. These, in the order of the amounts presently used, are: cobalt-60, iodine-131, phosphorus-32, gold-198, iron-59, sodium 24, strontium 90, carbon-14, sulfur-35, chromium-51, iridium-192, and cesium-137. With a few exceptions, these isotopes are used in clinical practice in the form of inorganic compounds. Radioisotope atoms have been incorporated in many hundred organic compounds. Most of these organic compounds have been used so far only in investigative work. There can be little doubt that some of these will gain significance in medical practice.

Radioisotopes are useful tools in diagnosis as well as in therapy. The recognized diagnostic uses of radioisotopes are:

1. Blood volume determination, including red cell and plasma volume, RBC life span, site of production (P^{32}, Cr^{51}, I^{131}, Na^{24}, Fe^{59}, and C^{14}, glycin).
2. Circulation time determination (Na^{24}, P^{32}, CR^{51}, RISA*).
3. Extracellular fluid volume determination (Na^{24}, S^{35}).
4. Cardiac output (Na^{24}, RISA).
5. Tumor localization (P^{32}, I^{131}, K^{42}).
6. Thyroid function (I^{131}).

The presently accepted therapeutic uses of radioisotopes may be listed as follows:

1. Radioactive phosphorus (P^{32}).
   a. In the form of soluble disodium hydrogen phosphate compound for intravenous use in blood diseases such as polycythemia vera, chronic granulocytic and lymphocytic leukemia, occasional cases of Hodgkin's disease, lymphosarcoma, multiple myeloma, and in early and advanced stages of breast cancer (experimental).
   b. In the form of insoluble col-

*Radioactive Iodinated Serum Albumin.

Dr. Low-Beer was professor of radiology at the University of California School of Medicine, San Francisco, Calif. He died in September. Material presented in this paper was prepared for the American Hospital Association's Committee on Use of Radioisotopes in Hospitals.

A bibliography prepared by Dr. Low-Beer is available in mimeograph form. Write to HOSPITALS, the Journal of the American Hospital Association, 18 E. Division St., Chicago 10, Ill., if you desire a copy.

Pictures illustrating this article were taken by Robert McCullough at Argonne Cancer Research Hospital in their laboratories at the University of Chicago.

loidal chromic phosphate compound
(1) For intravenous use in hepato- and spenomegaly due to polycythemia vera, chronic granulocytic and lymphocytic leukemia, and in selected cases of hyperspenism.
(2) For intraperitoneal or intrapleural use to control ascites or pleural effusion in carcinosis.

c. Externally topically, in plastic or blotting paper for the treatment of superficial skin cancer, wart, hemangioma (some forms only).
d. In the form of chromic phosphate for interstitial tumor infiltration such as of prostate.

2. Radioactive iodine (I^{131})
a. In the form of NaI or KI for hyperthyroidism, some cases of thyroid cancer, angina pectoris, myocardial heart disorders, and occasional cases of multiple myeloma.

3. Radioactive gold (Au^{198})
a. In the form of colloidal radiogold
(1) For intracavitary use in ascites or pleural effusion in abdominal or pleural carcinosis.
(2) For intravenous use for injection in hepatosplenomgaly in polycythemia, chronic leukemia, and in selected cases of hypersplenism.
b. In the form of gold seeds, gold wire for interstitial use in cancer of the lip, tongue, buccal mucosa, etc., and for tumor infiltration such as of the prostate.

4. Radioactive cobalt (Co^{60})
a. In the form of needles or wire for interstitial use in various forms of cancer.
b. In the form of beads and pellets for intracavitary use in the treatment of tumors of the bladder, sinuses, nasopharynx, etc.

A SCINTILLATION counter, which is shielded and collimated by lead and mounted for ease of handling, is used to determine localization of the radioactive material used in the therapy prescribed for the patient.

c. In the form of telecobalt units for external supervoltage radiation therapy of various forms and sites of cancer.

5. Radioactive yttrium (Y^{90})
a. In the form of colloidal radioyttrium for use in hepatosplenomegaly, polycythemia, chronic leukemia, and possibly in selected cases of hypersplenism.

6. Radiocesium (Ce^{137}) for teletheraphy

The wide applicability of radioisotopes in clinical practice leads inescapably to the following questions:

1. Are radioisotopes to be considered the same as any other drug?

2. Are there any precautionary measures necessary in the use of isotopes?

3. What qualifications should a physician have to use isotopes?

4. What are the requirements for establishment of a radio-activity laboratory?

The first question must be answered in the negative. Although radioisotopes chemically are similar to their non-radioactive counterparts, and thus from the point of view of biological action behave similarly to their non-radioactive counterpart drugs, they differ from them because their active agent is the radiation which is emitted in the disintegration of the particular radioactive atom. Depending on the radiation emitted and the distribution of the isotope-containing chemical compound in the body, the effect is either local or general (selective or diffuse).

When any ordinary drug is eliminated from the body, it loses its biological significance. Radioisotopes eliminated from the body, on the other hand, remain active as long as radioactive atoms are present, and therefore they may act as external irradiators. Depending on the half-life of the isotope, this may continue from a matter of days to many, many years. It is important to realize that while quantities of radioactivity are arithmetically additive, the biological effect increases in almost geometric proportions.

Strict precautionary measures are of paramount importance in handling radioactive isotopes. Ionizing radiations which these isotopes emit may have beneficial effects on the disease process in the particular patient. But in case of injudicious use they also carry potential danger to the patient, to the physician and technical personnel who administer the drug, the nursing personnel who take care of the patient and to the public as a whole—particularly when the excreta and waste products are not properly taken care of.

It is generally conceded that diagnostic procedures with radioisotopes can be carried out somewhat as a laboratory service. Many physicians advocate that radioisotopes should be freely accessible to any practitioner on a hospital staff. Because radioisotopes differ from the other pharmaceuticals or therapeutic agents by their radiation properties, such a position is shortsighted and based on erroneous assumption. This was recognized by the Atomic Energy Commission when it first started distributing radioisotopes for medical purposes. The AEC, as the main supplier of radioisotopes for clinical use, has set up regulations concerning uses and users of isotopes. These regulations limit use to medical people who are considered trained and experienced in the use and safe handling of radioisotopes. At first glance such regulations may appear unduly restrictive.

In discussions regarding these AEC regulations, it has often been pointed out that the licensed physician is not restricted in the use of insulin, cortisone, ACTH, strychnine, or any other drugs, and even the use of narcotics is not based on any further requirement than the license to practice medicine in a particular locality. It is asked, therefore, why should the use of the radioisotope drug be limited to special training and special authorization? When one realizes, however, that the use and the handling of the radioisotope drug involves potential danger and damage not only to the patient, but to the physician, the nursing staff, technical staff and to the public as a whole, one appreciates these restrictive regulations and instead of raising objections to them, welcomes them heartily.

Proper qualifications of physicians for use of radioisotopes is an extremely important educational problem. The diagnostic and therapeutic use of radioisotopes is taught in most medical schools in a very cursory way, or not at all. Radioisotopes are either not mentioned, or they are referred to as something far outside any clinical usefulness. Postgraduate training in the clinical use of radioisotopes is also limited, usually to residents in a few radiology departments.

The judicious use of radioisotopes both in the field of diagnosis and in the treatment of disease necessitates proper knowledge of the basic principles of radioactivity. Knowledge and experience concerning indications, contraindications, dangers and protective measures to be followed in the use of these unusual pharmaceuticals are imperative.

REQUIREMENTS FOR PHYSICIANS

According to the recommendations of the AEC Subcommittee on Human Application of Radioisotopes, the physician in charge of an isotope laboratory should have a minimum of three months' experience in active coöperation with a group authorized to use radioisotopes. The equivalent of at least one month in the actual handling of radioisotopes and management of patients treated with radioisotopes should be included in the experienee.

The requirements of the AEC concerning the training and experience of a physician are, however, not specific enough as they stand at the present time. Interpretation is left to a great extent to the preceptors, persons considered by the AEC to be qualified as teachers of the use of radioactive isotopes. Consequently, the recommendation for authorization to use radioisotopes depends to a great extent upon views of the particular preceptor, provided there is compliance with the minimum standards of the AEC. Some preceptors maintain that an individual can and should be authorized in the use of one isotope after he has seen five patients receive a test or treatment dose of a particular isotope. Other preceptors believe that training should include the fundamentals of radioactivity including instrumentation, protective measures, in addition to more adequate clinical experience (about 30 patients) with respect to biological reaction to treatment and proper selection of cases.

In this author's opinion, the existing requirements of the AEC concerning training and experience in the use of radioisotopes are inadequate. They do not insure the judicious use of radioisotopes, and thus they endanger the welfare of the public. This may result in utter discreditation of the use of radioisotopes.

In accordance with the different views of preceptors, there are radioisotope training courses offered which vary from five days to nine months.

The Oak Ridge Institute of Nuclear Studies offers a four-week basic course directed at training in general radioactivity, the management and safe handling of isotopes and in waste disposal procedures. This is followed by a training course in clinical application of isotopes. The Medical Division of the Oak Ridge Institute of Nuclear Studies accepts physicians for a more extended training on an internship basis for periods of three months or more.

There are several other institutions which accept trainees for varying lengths of time for basic and clinical training courses in the handling of radioisotopes. Information concerning these can be obtained through the office of the Director of the Radioisotope Division of the AEC, Oak Ridge, Tenn.

At the University of California, three types of courses are given. In the Donner Radiation Laboratory in Berkeley, general participation for a minimum of four months in all activities in the clinical uses of radioisotopes is required.

At the University of California School of Medicine in Los Angeles, a 46-week course is given, consisting of 40 weekly lectures and laboratory exercises, and ten all-day sessions in clinical management of patients. Mid-term and qualifying examinations are held. Candidates receive a certificate of efficiency. This course deals with all aspects of the use of radioisotopes, including basic principles of radio-

activity, calibration of instruments, sample measurements, diagnostic and therapeutic uses and protective measures.

At the University of California School of Medicine in San Francisco, a course is offered for radiologists and residents in radiology who are eligible for board examination, consisting of a one-month basic course including instrumentation, protection, waste disposal problems and one month of clinical training in the diagnostic and therapeutic uses of isotopes. For non-radiologists, a three-month course is given to gain more knowledge and experience in the various aspects of the why, when and how to use isotopes. Eligibility is decided by an entrance examination to ascertain whether the student has some knowledge of radioactivity. For those lacking such knowledge, a correspondence course in general radioactivity is offered as preliminary to the isotope course.

In addition, short, informative courses through the Extension Division of the School of Medicine in San Francisco are given in the form of lectures of one or two day's duration. The courses aim to inform the participants about newer advances in the field of radioisotopes.

While there are those who advocate complete freedom in the use of radioisotopes and demand complete removal of all restrictions, there are others who are frantically afraid of radioisotopes and in their hysteria oppose any use of radioisotopes in medical practice. This latter extreme is as unjustified and unreasonable as the first one. Untoward effects from radioisotopes can be avoided when the problems involved are handled with appropriate know-how.

One important point which must be kept in mind is that damage from radioisotopes, as from other ionizing radiation, is rarely immediately visible; it develops rather insidiously and becomes manifest often after many years of chronic multiple exposures to small doses of radiation. Usually the individual exposures themselves do not produce either any observable symptoms or any early or late damage. It is the cumulative exposure and the cumulative effect of the multiple small doses which result in irreversible damaging changes to the tissues.

On the question of radiation safety and protection, there are two schools of thought. One school advocates that all procedures with radioactive substances be so organized that persons involved should not be exposed to any radiation originating in the type of work in which they are engaged. The other more widely accepted school of thought is based on the theory of maximum permissible exposure.

In clinical work the latter principle may be the guide, with the added provision that all personal exposures should be kept at minimum practicable levels below the maximum permissible exposure. The "maximum permissible exposure" as set by the International Committee on Radiation Protection recommends that any exposure to the whole body or gonads should not exceed 0.3 roentgen (r) or 300 milliroentgen (mr) per week measured in free air, or 0.5 r equaling 500 mr measured on the body surface. For hands and forearms, the maximum is 1.5 r per week for x-ray and gamma ray energies less than 3.0 million electron volts (MEV). Beta radiation should not exceed 500 millireps (mrep) or 0.5 r per week in the surface layers of the skin.

The maximum permissible exposure is based on the assumption that radiation in the amounts set forth above will not result in any late damage at this exposure rate for whatever length of time the individual is exposed to these amounts of radiation. These standards, one must realize, are arbitrary and have been changed in the course of the past 25 years from almost double to the present figures. Permissibility is based on our present knowledge. The future may show that even the presently considered permissible amounts of radiation are not in the safe range.

RADIOISOTOPE COMMITTEE

The regulations of the AEC on the allotment of radioisotopes are in some respects equal to a licensure. These regulations provide authorization for use of radioisotopes to individuals in hospitals or in private practice. In a clinic, hospital or medical group, authorization for the use of radioisotopes is conditional to the establishment of a radioisotope committee. The radioisotope committee is considered the guarantor for the safe handling and expert use of radioisotopes.

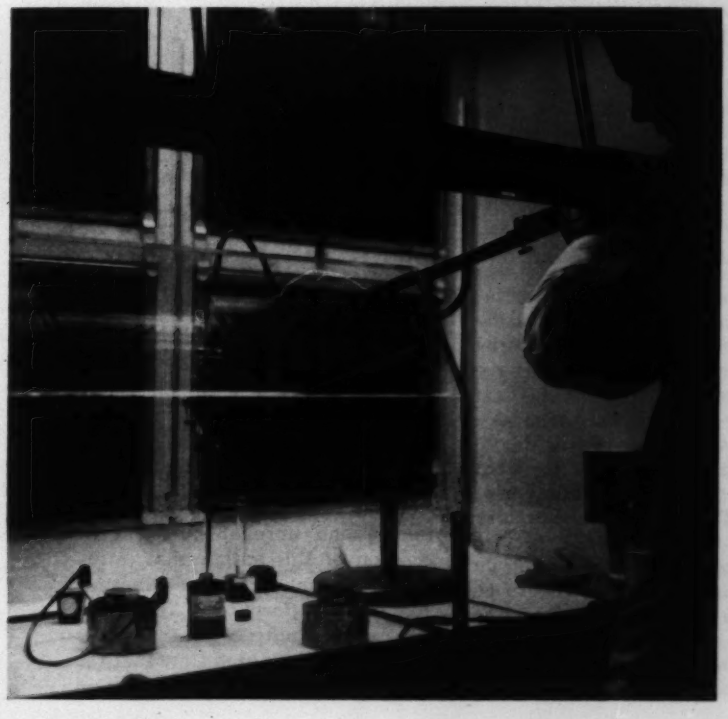
In conformity with AEC regulations a radioisotope committee should be established by the hospital board. It is advisable that the members of this committee be nominated by the professional staff of the hospital. According to AEC recommendations, the committee should include a clinical therapeutic radiologist, a pathologist, an internist, a hematologist, and a radiation physicist. The Commission suggests that the other fields of specialization represented on the committee be determined by the nature of the program being conducted. From the point of view of the Commission, the therapeutic radiologist might perform the duties one would expect from a radiation physicist. Each situation should be judged on its own merits. Recommendations concerning membership are intended as basic guides only, and considerable latitude in interpreting the specialty requirements for each particular situation is allowed by the AEC.

At least one member of this committtee must be a physician experienced in the safe handling of radioisotopes, in the measurement of radioactivity; he should be experienced in radioisotope dosage for various diseases and familiar with the problems of radioactive waste disposal.

The AEC regulations do not include recommendations concerning the membership of other than medical persons on the radioisotope committee. In this author's opinion, the committee should include the supervisor of nurses and the administrator of the hospital or his representative. The participation of the nursing staff on the radioisotope committee of the hospital is advisable for various reasons. The first, and most important, is that by participation the nursing staff will be better familiarized with the type of radioactivity work carried out in the hospital, the dangers associated with such work, and the protective measures

PREPARING AN isotope for administration. The handler is protected by a lead wall of bricks as he manipulates a remote control leverage device to move the isotope from its container (smaller can in foreground) to the administration container. The container (left) is to catch any drippage from the pippette after pipetting is completed. The paper is an absorbent type to blot up all liquid and make decontamination easier should a spill occur.

THE HANDLER is preparing phosphorus^{32} for administration, using lucite as shielding rather than a lead brick wall. The entire setup is placed inside a permanently installed hood. Such an installation is for the large hospital.



to be taken to avoid such dangers. When a representative of the nursing staff participates in this work on the policy-making level, she may help to dispel the baseless fears of uninformed personnel concerning radioactive materials and radiation as a whole.

The inclusion of the hospital administration or his representative on the radioisotope committee may contribute to the development of the radioactivity and radioisotope service programs in the hospital by affording firsthand information to the board of directors through the hospital administrator. This seems preferable to relying on the administrator to act on requests from the physician in charge or from the radioisotope committee.

The radioisotope committee should hold meetings at regular intervals. It is suggested that such meetings be held at least four times yearly.

There should be informational lectures at least once yearly for nurses, clerical personnel, janitors and others by members of the radioisotope committee concerning radiation safety, the nature of the dangers involved and waste disposal. These will increase the competence and enhance the sense of security of hospital personnel who are in contact with radioactive materials. There should be lectures on radiation safety at least once yearly for members of the medical staff. These lectures should also deal with radioisotope activity in the hospital and the services which can be rendered by the radioisotope laboratory.

The AEC requires no isotope committee in a hospital when a private physician in the community, rather than the hospital, carries a personal authorization for the use of isotopes, although the hospital may accept the physician's patients to receive isotope therapy in the hospital or for hospitalization after having received the radioisotope treatment elsewhere. Authorization for private physicians properly qualified in the use of isotopes was instituted in December 1953. Such authorization to use radioisotopes in private practice calls for arrangements with the hospital in the community to insure that the hospital will be willing to accept patients who have

received radioisotope treatment in the doctor's private office or who will receive radioisotope treatment in the hospital. It requires that arrangements be made to provide the hospital with the necessary radiation detection instruments and instructions for the care of patients. In this author's opinion, the same organizational requirements should be required irrespective of whether a hospital or private physician in the community is granted authority to use isotopes.

Professional responsibility for the management of the radioisotope laboratory should be vested in the physician on the hospital staff who is best qualified by training and experience in the clinical use of radioisotopes. Whether this physician is a radiologist or from another specialty is of less importance than the specific training and experience of the individual in the use of isotopes. In many hospitals the radiologist, and particularly the radiation therapist, will be best qualified to be the physician in charge of the radioisotope laboratory, for reasons of insurance and legal responsibility as well as training and experience. However, this is not invariably the case, and it should be reiterated that the best qualified individual should always be the choice for this position.

The hospital radioisotope committee should designate the physician in charge of the radioisotope service as the radiation safety officer responsible for carrying out provisions of safety and maintaining proper records of isotopes ordered and received, the date and quantities of isotopes used, the names of patients on whom the isotopes are used, the physician who administers the isotopes, the safety measures taken, the monitoring of areas involved and the means of disposal of wastes.

The physician in charge of the radioisotope service should organize a radiological health safety program. Persons who are regularly handling radioisotopes should be included in this program. The health safety program should depend on the extent of radioactivity work in the hospital. It should include medical examinations, film badge service, periodic monitoring of the areas. It is advisable to unify any health safety program in the radioisotope laboratory with that of the radiology department.

Procedures adopted in the radioisotope laboratory will depend upon the training and experience of the director of the laboratory. Whether one or another treatment or measuring method is adopted is not critical, as long as the measurements are accurate, the procedures safe for patient, physician, and personnel, and disposal of waste is carried out under proper precautionary measures.

The question of advisability or necessity of creating a position for a radiological physicist in an average-size hospital is often discussed. It is pointed out that it may be uneconomical to engage a radiation physicist on the full-time staff of the hospital. In fact, the AEC regulations make no such requirement. Rather, the recommendation of the AEC to have a radiological physicist on the isotope committee can be interpreted as suggesting that this position is a consultative one. It is obvious that in smaller or average size hospitals there would not be enough work to employ a full-time radiological physicist. Employment of a physicist on a regional basis and sharing his services among several hospitals can satisfactorily solve this problem. Responsibilities of the radiological physicist include periodic calibration and maintenance of the physical measuring equipment in the radioactivity laboratory, and also periodic survey of the equipment in the department of radiology as well as to advise on radiation safety procedures.

RADIOISOTOPE LABORATORY

As in any other type of hospital service, it is necessary to set aside an area for a radioisotope laboratory. A great many designs have been advocated, from a one-room laboratory to a radioisotope department occupying an entire hospital wing. The subject has been very well covered in a number of articles. The design for laboratory facilities for an isotope service must be governed by the program to be undertaken. It will also be influenced by whether existing facilities are to be adapted or whether new facilities are to be constructed. When existing hospital space is to be adapted to the requirements of a radioisotope laboratory, it is most satisfactory to provide only for current and easily foreseeable needs. When new construction is to be undertaken, on the other hand, it will be a less expensive long-term investment to plan for increasing use of the isotope service and accordingly to provide for future expansion of facilities. For even a very limited activity, however, it is advisable that two rooms of adequate size be set aside for a radioisotope laboratory. One room should be used for preparation of radioactive material and the other as an *in vivo* measuring and treatment room.

Room design. Rooms designed for the use of radioisotopes are similar in most respects to rooms which are used for general laboratory and treatment purposes. The terms "radiochemistry laboratory" or "hot lab" may sound impressive, but means no more or less than a receiving and dispensing place for radioisotopes and for collection of samples such as blood, urine, feces, which are to be measured for radioactivity and other contaminated materials. Such laboratories actually are far from "hot" unless contaminated by careless handling of the radioactive materials. The radioactivity laboratory must, of course, include appropriate lead containers designed to hold radioactive materials in quantities varying from a few microcuries to several hundred millicuries. Radioactive material must always be stored in such a way as to protect fully the personnel working in the room.

Location. A question frequently arises concerning the most suitable location within the hospital for the radioactivity laboratory, especially with respect to its proximity to the x-ray department. It is argued that radiation background in the vicinity of the x-ray department may affect measurements in the isotope laboratory, making such measurements inaccurate and unreliable. It is the opinion of this author that if radiation from x-ray machines so markedly affects the radiation background outside of the x-ray rooms, then it is high time that the safety of all workers in and around

the x-ray department be investigated. There seems no reason in fact why the isotope laboratory should not be established within a properly safeguarded x-ray department. It is obvious that rooms for measuring radioactivity should not be adjacent to treatment or diagnostic rooms. Investigation of radioactivity background in the isotope laboratory should be checked with x-ray machines idle and in use, and with the x-ray beam directed away from and toward the isotope laboratory.

Disposal of Material. The problem of disposal of contaminated material, generally referred to as waste disposal, may vary with the quantities of radioactivity involved and with the location of the hospital. In coastal areas, arrangements can be made for pooling radioactive waste materials and disposing of them at sea. In inland areas burial of radioactive waste is usually practiced. Arrangements by the safety officer must be based on information obtained from appropriate authorities and on rules and regulations concerning radioactive waste disposal in the particular locality.

RECORDS AND REPORTS

The AEC Radioisotope Distribution Regulations, Title 10, Atomic Energy, US AEC, Part 30, Radioisotope Distribution, from the code of Federal Regulations and the Federal Register, specifically state the requirements concerning keeping records and reports. Similarly, the procurement of radioisotopes that are transferred from one institution to another is regulated by the AEC. It is of paramount importance that procedural regulations extend to accurate bookkeeping concerning any dose of radioisotope dispensed from storage. Records must include type of isotope, chemical form, amount in millicuries, name of patient, name of doctor to administer the isotope, signature of the receiver (nurse) and initials of dispensing person. The original should be kept, a copy sent with the isotope and included in the patient's chart. Similarly, any dose of a radioisotope administered to a patient should be recorded immediately in the patient's chart.

An "RI" sign should be conspicuously placed on the outside door of the patient's room. The regular AEC radioisotope sign should be attached to the patient's bed. Patients who receive radioisotopes such as radiogold in the abdominal cavity, or radiocobalt for bladder tumors, may have their bed positions reversed when they are in a ward or more than a two-bed room. By reversing the bed and placing the patient's head toward the center of the room, a conspicuous sign is provided, and also due to distance some degree of protection is afforded persons moving in the center aisle of the room.

EXCRETA DISPOSAL

Patients who receive diagnostic doses of radioisotopes up to 1 mc amounts may have urine and feces disposed in the usual manner. Of course this must be dependent upon the number of patients and the quantities of radioactivity disposed at any given time. It is advisable to wear rubber gloves when collecting or measuring urine or feces specimen or emptying bed pans or urinals. Urinalysis, if necessary, should be carried out in the radiochemistry laboratory. The radiation protection and safety measures to be followed for patients who carry radioactive material in amounts between 1 and 30 mc (radioiodine, radiogold, radium) should be decided upon by the safety officer appointed for the unit.

Patients who receive radioactive material in doses higher than 30 mc should have on the outside of the door of their room, in addition to the RI sign, the magenta on blue or magenta on yellow AEC sign. All excreta from patients who receive more than 30 mc radioiodine or radiogold should be collected and delivered to the radiochemistry laboratory for monitoring and proper disposal. (This is important also for determination of the "effective" dose). Linen and all other objects leaving the patient's room should be properly monitored and if significantly contaminated, they should be collected and delivered to the radiochemistry laboratory for storage until complete radioactive decay, or for proper disposal. There shall be a special waste can at the patient's bedside to collect disposable tissues, linen, etc. This special waste can shall be properly marked and monitored.

The question is often discussed as to what is the minimum amount of radioactivity in a patient which should necessitate hospitalization. In this author's opinion, it can be stated that apart from medical reasons, patients with less than a 30 mc dose may be kept on an outpatient basis. All patients who receive more than 30 mc of any radioactive material should be hospitalized. For example, those patients who receive more than a 30 mc dose of radiogold should be kept in the hospital, but not necessarily longer than five days. Patients who receive radioiodine in higher than 30 mc doses should be hospitalized for a minimum of ten days. In general, the half-life of the radioisotope and the excretion rate should govern duration of hospitalization for these patients.

It is important to realize that a patient who has received amounts of radioactivity which make hospitalization advisable may cause significant exposure if autopsy is performed. Therefore, previous to autopsy, the radiation safety officer shall monitor the body to establish the degree of possible radiation hazard. The radiation safety officer should be present at autopsy, and he should monitor organs, fluids, etc. The pathologist should wear thick rubber gloves. Distance and speed of procedure are of importance.

Precautionary measures must also be taken to protect the undertaker from undue exposure. Previous to release of the body the undertaker should be informed of any possible hazard due to radiation. He should be briefed by the radiation safety officer concerning the handling of body fluids during embalming.

The literature is abundant concerning organization and procedure of radioisotope laboratories in the average size hospital. Official handbooks by the National Bureau of Standards are particularly recommended as guides. Of these, the following handbooks should be on hand in every radioisotope laboratory. All new handbooks should

(Continued on page 156)

medical bedside teaching and the patient

JACK KARPAS, M.B., Ch.B.

WHEN A PERSON gets sick and is compelled to enter a hospital, his personality undergoes a change which must be understood by all those who serve him. He is no longer the same individual he was in health at his home or in his place of business. The fact that he is sick and in a strange environment (strange almost always to him) precipitates an understandable regression in his emotional status.

He is in a complex, if not altogether new, atmosphere of activity in which he is only one unit. His perceptive faculties are keyed up. He is sensitive to every change in expression of the features of those who should be serving him. Every sigh, every sight, every odor and every change or lack of change in tone or attitude, is examined anxiously with all of the concentration of an individual who is concerned only with himself. He looks upon the physician, the nurse and the house staff as special people who somehow control his destiny. They are the people who have promised to cure him of his pain and to allay his fears. His relation to his immediate physician is akin to that of a child in relation to its parents. He feels entirely dependent upon those who now surround him—strangers rather than relatives. While he may be free for the moment from the strains and stresses of ordinary living, and temporarily in a house of refuge and security, these factors are overbalanced by the effect of his illness on his emotions. It takes great effort to convince him that he is safe in the care of skilled people.

In circumstances like these, does the presence of the patient in a teaching hospital create any special problems either for the hospital, its staff or for himself? I speak here of a "teaching hospital," not in the narrow sense of a university hospital or a hospital affiliated with a university, but of "a hospital that teaches," which should include practically every hospital. For the physician and the nurse, teaching in a hospital unquestionably creates problems. We must, however, think of the patient first and ask whether the situation creates a superimposed problem for him. Does he, for example, have the feeling that he is going to be a subject for "experiment" or for exposure before students? If so, what is his response to such a situation, and in particular, how does he react when he snatches words about his sickness which may be discussed thoughtlessly at his bedside? We must be sympathetic to his natural desire to protect his physical body, his sensibilities, his private life and the fears which have overtaken him body and soul. A female patient obviously presents a more sensitive situation to her medical attendant.

The truth of the matter is that a patient is most safe in the teaching hospital where the teacher is required to be keen in diagnosis and therapy in the presence of a critical audience of students. Such an advantage, however, is not acknowledged and acted upon by many individuals. In any case, it is for the patient as well as for the others whose awareness of good medical care is more knowledgeable, that we must plan. The element of fear, and upset emotions generally, are matters of degree, and the fact is that few patients enter a hospital who can free themselves of such handicaps.

The pedagogic methods of bedside instruction for medical students and for their training after graduation are fairly standardized and leave little to be desired. They can, however, be exercised in such a way as to deny comfort to the patient and postpone his cure. The patient, in the end, is left with unpleasant memories of a hospital that should, in reality, have his undying affection. The outstanding problem which confronts us in situations like these is the actual teaching which is done at the bedside of the patient within his sight and within his hearing.

In order to analyze this problem, the Hadassah University Hospital in Jerusalem prepared a questionnaire to determine our patients' attitudes toward bedside teaching. Hadassah is the teaching hospital of the Medical School of

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Dr. Karpas, director of hospitals, Hadassah Medical Organization, Jersualem, Israel, delivered this address before the Ninth International Hospital Congress in Lucerne, Switzerland, in June 1955.

the Hebrew University. It is a voluntary, nonprofit 470-bed hospital with a strong extramural program. The great majority of patients in this hospital are the financial responsibility of an insurance group or belong in the part-pay classification. Approximately 10 per cent are nonpaying, and there are a comparatively small number of private patients.

As a result of the responses to this questionnaire, it became clear that the largest number of patients did not object to bedside teaching. It did not, in fact, seem to matter whether the individual responding was an extrovert or an introvert. The personality of the individual did not appear to be the determining factor. The extrovert enjoys the presence of others around him, and teaching situation experiences like these somehow give to such people a sense of importance. We are all familiar with the woman who loves to talk about her operation in after days. The introvert, on the other hand, has more curiosity and seeks eagerly to know more about himself and his surroundings. The teaching situation sparks this curiosity. Whatever the psychological characteristics of the individual, however, none had any serious objection to bedside teaching.

The approach of the physician and the nurse to the patient is a huge determinant in the patient's reaction. It is, indeed, the most important factor. The manner in which the patient is handled, what is discussed in his presence and the amount of attention he receives were the prominent points that emerged from the questionnaire. In other words, it is how as well as why the teaching is done that influences the reactions, for better or for worse, of the sick in such hospitals. The question is, does the patient have the feeling that he is benefiting by the application of the teaching program to his particular case, or is the reverse true with all of its unhappy consequences? Our survey satisfied us that the faculty is mindful of the therapeutic results—good, bad or indifferent—of medical care on a teaching basis. Patients are aware at the outset that they will be exposed to student teaching because ours is the only university hospital in the country. It is for these reasons that I assemble and crystalize our conclusions on the procedure followed by our staff as well as the attitude of the patients to it.

To begin with, I must emphasize a truism which is followed more in the breach than in the observance. We must practice what we preach when we say a patient—any patient—must be treated, not only with skill and insight, but also with respect. Nor should we forget that our pedagogic program is worthless without him. We must not suffer him to make any sacrifices at such a time for the benefit of others. If there are to be sacrifices, they must be made by the teacher and not by the sick man.

PATIENT HAS A NAME

It is a serious mistake to refer to a patient by a bed number or by any other bed designation. He has a name and prefers to be called by that name. Whether to use a first name or last name is a delicate question which can only be decided by taking the patient's personality into full account. Some prefer it one way and some the other. The manner in which the physician addresses his private patient in his outside office is a good guide to his performance in the hospital. Several of our patients reported that some attending staff members prepared the way by introducing them to the students, thus putting both parties at ease from the start.

The bed covers should not be disturbed or removed without courteously asking the permission of the patient to do so. Nor should he be ordered to undress or even to sit up; he should be asked politely to do so. The patient should be included as far as possible in any discussion that is held in his presence. The teacher should turn to him from time to time with a tactful question, either to amplify a student's inquiry or to corroborate a theory. The patient must be made to feel as comfortable and as important as possible. He should be made aware of the fact that he is contributing in this way to medical knowledge and that he is a person who happens to have an illness which requires study for the benefit of the younger generation of physicians.

The teacher must come to the bedside prepared for the discussion to follow and should be ready to control its course. He should read the patient's history carefully before he approaches the bedside, in order to develop the salient points of the case and guide the student carefully in his presentation and minimize the commission of indiscretions. Patients resent the person who blurts out details of their private lives in the presence of strange students and too often within earshot of other patients. Some persons unfortunately involve the patient this way and do violence to the personal and confidential relationship prescribed by medical ethics.

It is not enough to deal considerately with the patient at his bedside. This attitude must prevail in his absence. When the teacher instructs students on the subject of case presentation, special attention should be given to any possible objections which a sick man might have in such circumstances.

Discretion is the essence of medical teaching, and it does, in fact, have legal implications. I am reminded of an instance in which a patient suffering from jaundice heard the teacher ask the student in his presence whether an injection of any kind had been administered. The student replied that an injection had been given and that the possibility of serum jaundice could not be ruled out. The patient happened to be a lawyer and promptly suggested that he had been given cause for legal action and indemnity.

As I have already stated, patients want their confidences respected, and, the more personal the confidence, the greater the want. Thoughtless abuse of such information makes the path of the teacher difficult. Joking and talking about irrelevant matters are out of place on the teaching scene and can be very annoying to the patient whose own mood is serious, even anxious. Before examination is undertaken, the patient must be made comfortable. It must never be forgotten that he is physically disabled. While certain features of his case may be and should be

demonstrated in class, no one enjoys having his abdomen palpated by several students, unless he can somehow be convinced that this repetitious procedure will do him good. Listening with a stethoscope is in a somewhat different category, provided, however, that the patient is not exhausted by the teaching session. As a matter of good habit, examinations and procedures under anesthesia should also be done considerately and gently.

Many patients stated they would prefer to have students return in small groups to examine them rather than to do so in one large group during the teaching period. Elicitation of reflexes can be tiring and occasionally self-defeating if repeated often enough. The inflation of a sphygmomanometer bag can be uncomfortable, and repeated use of the ophthalmoscope in an intensive session can be harmful in more ways than one. Painful tests and examinations are, of course, in a class by themselves.

An unfavorable diagnosis or prognosis should never be discussed in the presence of the patient. He should be spoken to in words he can understand, words that will sustain his courage as he struggles with his illness. Sick people are very prone to misunderstand or misinterpret what is being said about them in authoritative medical quarters. If they are in a position to obtain inaccurate information about themselves, they often develop phobias and imagine themselves suffering from ailments more serious than they actually are. When situations of this kind are exaggerated in the minds of the sick, it takes a great deal of subsequent explanation to dislodge the spectre. Discussion of diagnosis and prognosis belongs in the conference room after rounds and not in the presence of the patient.

Many patients, and indeed many physicians, hold to the view that if the patient has an understanding of the treatment about to be administered, he not only accepts the procedure, he coöperates with it emotionally. That the mind influences the body in situations like this is beyond question. On the whole, our conclusion was: while treatment should be explained to the patient by his physician, no discussion of the pros and cons of this treatment should take place in his presence.

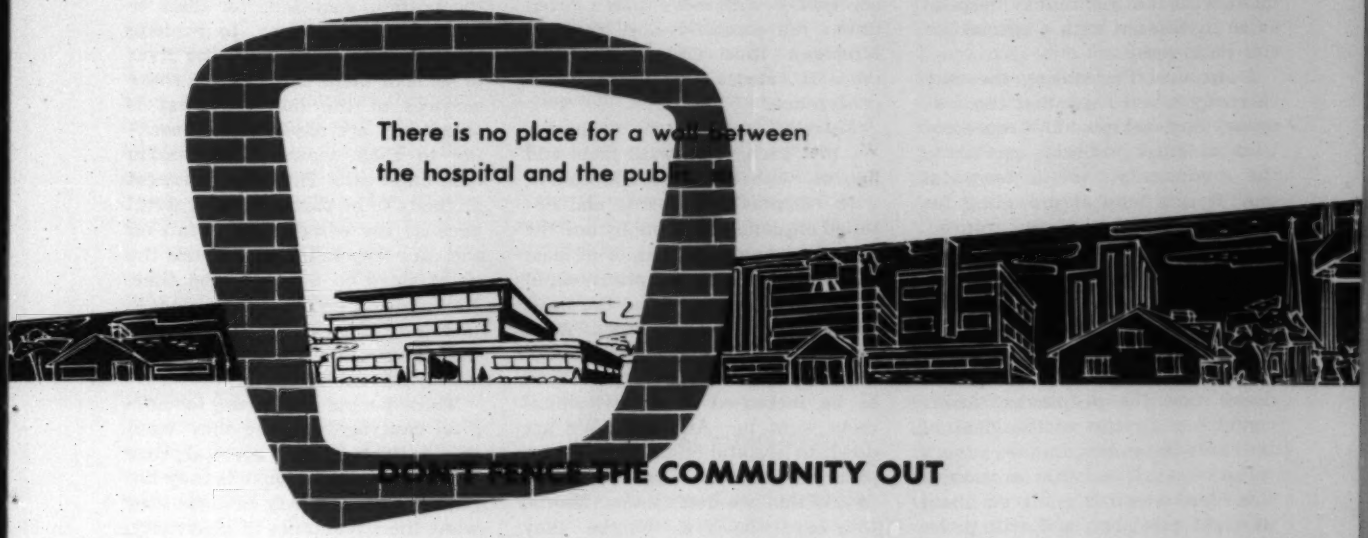
In view of these factors, we asked key members of the nursing staff, who are neutrals in a sense, to express opinions about this problem. This strategic group of hospital personnel was firmly of the opinion that almost every teacher-student conference leaves a crop of disturbed, anxious, and even miserable, patients. The nurses reported that in spite of the best precautions, indiscretions occur. Although patients were willing to make allowances and did not complain, the nurses felt that this might be due to fear of antagonizing the attending staff.

In order to overcome any misconception or misunderstanding on the part of the patient, we adopted the routine of sending an intern to talk to each patient, answer his questions and put him at ease after teaching rounds. We consider such a procedure a vital step in the teaching program.

There is universal agreement on the values inherent in the teaching program. I have tried to point out here the impact of this program on the nerves, and ultimately on the illness, of the sick man. We earnestly invite more attention to this problem in the hope that every patient as an individual will have the benefit of the teaching program without loss of any kind and, indeed, with greater effect. ■

nutmeggers proud of leaders

THE ELECTION of Albert W. Snoke, M.D., as president-elect of the American Hospital Association inspired a rather proud listing in the Connecticut Hospital Association's journal. Our friend in the "land of steady habits" (as Connecticut Yankees call their state) point out that Dr. Snoke's election "adds one more name to the Connecticut list of distinguished leaders in the hospital and related fields." The bulletin cited these other Nutmeggers: Agnes Ohlson, R.N., president of the American Nurses' Association; Francis J. Braceland, M.D., president-elect of the American Psychiatric Association; Ira V. Hiscock, Sc. D., president-elect, American Public Health Association; Lucille Refshauge, president-elect, American Dietetic Association. ■



DON'T FENCE THE COMMUNITY OUT

WILLIAM S. McNARY

IN THE 1930's, when practically all of our hospitals faced serious financial difficulties and none knew what the future had in store, they found one very important asset on the black side of the ledger. This was the confidence of the people.

The 1930's were not years marked by great public confidence in anything. But the community hospital appeared an institution apart. The people had confidence in the sincerity and integrity of the social purpose of the voluntary hospital. It was this simple confidence of the people that gave our voluntary hospitals both the opportunity and the necessary time to create their own prepayment program through Blue Cross.

This asset of public confidence and what has been happening to it form a subject that has tempted me for some time. For I remember only too well that Blue Cross in those early days had little enough to back its promises, and even less to work with, if we left out the sincerity and integrity of the hospitals and the confidence the average citizen had in them.

Through prepayment, built with the dimes and quarters of millions of people, the hospitals succeeded in making one of the most remarkable transitions of all time. They pulled themselves by their bootstraps, as it were, out of the dated and unworkable economics of early nineteenth century philanthropy and into the mass-marketing economics of the twentieth century industrial society. And they did this on a shoestring and confidence.

Today, our hospitals are used more than ever. Everyone knows these days that the hospital is the best and safest place to be cared for if he is sick or injured. The people are giving so much thought to the hospital that an estimated hundred million have provided themselves with some kind of prepaid hospital coverage. Many government and public agencies, including the administration in Washington, are actively interested in providing all people with hospital protection As a matter of fact, the hospital's popularity has created a new problem, undreamed of 20 years ago—that of keeping people out of it who do not really belong there.

Nevertheless, it must be noted that the hospital's current popularity is based upon confidence of the people in the quality of services the hospital is providing. This type of confidence was not so apparent 20 years ago. The kind of social confidence that the hospital enjoyed so widely 20 years ago is not so apparent today. To be truthful, it is sometimes not apparent at all.

BOOMING MARKET

Yes, the market for the very desirable services of our hospitals is booming. The people are anxious to get as much protection as they possibly can against the cost of hospital care. Blue Cross has become a household word. It is all very gratifying; and for the time being this popularity, this widespread recognition of prepaid hospital care as an everyday necessity, offers its many compensations. But the fact must be reckoned with that too many people are carpingly critical of the hospital; too many show only impatience when you talk about the hospital as a nonprofit service; too many are downright cynical. We in Blue Cross who have to deal with the people each hour of the day, day after day, hear the question more and more often: "What price nonprofit?"

Most of you know, I am sure, that I am not making a personal observation. Many respected hospital people you and I both know are vitally aware of this dangerous development. Some of these people are very disturbed by the abundant evidence of spreading disillusion-

Mr. McNary is executive vice president and general manager of the Michigan Hospital Service, Detroit. This article is based upon a paper delivered to the Mid-West Hospital Association meeting in Kansas City, April 1955.

ment with the community hospital as an institution with a special social philosophy.

I am sure I'm stating the case correctly when I say that the voluntary hospital must first represent a *social* ideal in health service to the community, not a *technical* one. It is a way of providing for care of the sick and the injured, and for the advancement and protection of the health of the whole community, not just the technical and institutional services involved. If this is correct—as I am sure it is—then the problem posed by evidence that the people are losing confidence in the social ideal of the voluntary hospital is a very serious one. I feel that erosion of this idea, which is going on about us right now, can and will prove fatal to our whole voluntary hospital system, if not stopped.

Some hospital people feel that the problem could be successfully met with an ambitious public relations program.

Some feel that the attitude of the people would change if they were made to understand, through a systematic public relations program, how the hospital has become big business and must in the public interest operate on business principles.

Some feel that the public must be made to understand how complex hospital operation has become; and that this complexity, necessary to serve the public, would explain why the hospital cannot behave like the simple, friendly institution of the past.

Some feel that the whole problem might be solved by educating the public to the factors behind hospital costs, for they think that it is the constantly rising cost of hospital care that is the source of the whole problem.

Undoubtedly there is merit in all of these suggestions. I must confess, however, that I am not entirely convinced. I do not believe that the people are as ignorant of what has happened to the hospital as some hospital people think. I do not believe that statistics, charts and technical explanations justifying hospital costs can really solve the basic problem. I'll give you a few reasons why I think as I do.

Not too long ago I found it necessary to spend two solid days in conference with more than a dozen union representatives. A raise in Michigan Blue Cross rates had made it necessary to arrange this conference.

My staff and I came prepared. We met each gripe with facts and figures, with statistics and charts, with reasoned arguments and detailed explanations. One by one the criticisms were silenced, or at least tabled. Finally, on the afternoon of the second day, we faced the basic issue, and here is the gist of what we heard:

"You say Blue Cross rates had to be increased because hospital costs went up. All right. We are down to hospital costs. Maybe hospital costs are not too high. The fact is that we don't know. Maybe they are too low. Maybe they should be higher to give us the services we want. We don't know. Maybe hospital costs are just right. Again, we don't know. The hospitals are supposed to be community institutions. But they operate without anybody knowing what they are doing or why. As it seems to us, they up costs as they please. You say Blue Cross cannot control their costs. Nobody can. Nobody has anything to say about it. They haven't shown us that they care what happens. All Blue Cross does is raise rates to meet hospital costs, which you say you cannot control. You are just a collection agency for the hospitals."

SENSE OF CONTACT LACKING

I listened, and thought, and tried to figure out what to say. Here was a problem which the figures and facts could not even touch. I could explain all over again—and we did a pretty good job of it in the first place—and I would become in their opinion just an apologist for the hospitals on top of being their "collection agent." These people did not want to become authorities on hospital costs. It was a field in which they felt strange. What they wanted was a sense of contact with the hospital, the feeling of confidence in the purposes of the institution, which I could not possibly give them with statistics or explanations.

I might have tried various devices. I knew from experience that I could not change their thinking by pointing out to them how much the hospital had done for them to make them healthier, to prolong their lives, even to save the lives of some of them. They expect these services of the hospital. That is what they are paying for, according to their views. These union men build cars. They do not expect anybody to be particularly grateful because the wheels do not fall off the cars they build, or because the paint stays on a fairly long time. No builder, they would say, tries to justify high costs by pointing out that the roof on the house he built is staying on.

These people are paying for hospital coverage because they want the advantages of hospital care when they need it, just as they are paying for electricity because they want the advantages of electricity. Technical services were not the issue in this discussion. The issue was this institution which calls itself a voluntary hospital, which operates on a nonprofit basis, which looks to the community for support, appears to them to handle the business of financing hospital care without any regard for the people or what the people may think about it.

Let me also repeat that it was not the actual cost that these union representatives made the final issue. It was the secluded way the hospital operated; it was the hospital's seeming remoteness from the economics of their everyday lives which they made the basic issue. It was, if you please, the rumors and the hearsay they heard about hospitals.

The problem we faced there, which we face repeatedly day after day, has to be stated plainly, if we are to do anything about it. Too many of the hospitals have transformed prepayment—their own great contribution to the public welfare—into a wall between themselves and the people. No kind of public relations magic can penetrate this wall so long as it is there. The people want to be a part of their community hospitals. They want to be insiders, not outsiders.

Let us look at the facts. While exact figures are not available, we can safely estimate that nearly 60 per cent of our civilian labor force has hospital coverage. From 37 to 40 million American breadwinners have some kind of hospital cover-

age for themselves and their families.

These people are paying for their Blue Cross or other coverage month after month, the same as they pay for gas, electricity and telephone service, with this difference. The gas, the telephone and the electricity they use every day of the week. But their hospital protection is something they may not use for years. Of necessity, they have a different sense about the fairness of the cost of each. There is another difference to consider. Gas and electricity are supplied by public utilities. The people do not have the same attitude toward utilities as they have toward their community hospitals. Nor would we want the people to come to regard hospitals as simple public utilities. This would spell the end of *voluntary* hospitals.

Every increase in hospital costs affects the paychecks or the over-all take-home-pay of these millions of Americans. It affects their family budgets. It has repercussions in the unions to which so many of them belong. And their reaction is going to be stronger for the reasons I have cited. All of us react more strongly to actions we dislike or which disappoint us when they are committed by persons from whom, because of our particular regard for them, we do not expect such behavior. The people expect the hospital to behave differently, and they behave differently toward the hospital. We want them to continue to behave differently toward the hospital, too. Let us not forget this.

The hospital is the heart of this whole new, sensitive social and economic area. What happens in the hospital is felt in thousands of personnel offices, in the offices of top executives and at endless collective bargaining tables. Prepayment is not something outside the hospital; it is the new nervous system connecting the hospital and the people.

Let me give this some concreteness. In 1946, Michigan's Blue Cross Plan annual payments to hospitals averaged about $8 per member. In 1954, the average per member was close to $25. During the same period we almost tripled our membership.

Now, tripling our membership in this short period was a job that involved many important changes in the thinking, attitudes and office operations of thousands of enterprises. The growth of such a development as prepayment is a disturbing factor. When on top of this disturbance we were forced to raise our rates every little while in order to more than triple our payments to hospitals—and do it in eight short years—you can understand how sensitive every one of our more than 16,000 enrolled groups became to the problem of hospital costs. Management is as sensitive as the employees, let me assure you.

COMMERCIAL COMPLICATIONS

There is another problem adding to public exasperation and public disillusionment with what is going on in the health care field. The U. S. Chamber of Commerce recently stated in one of its publications that about 900 insurance companies in this country are today selling hospitalization coverages. There are more companies selling health insurance than automobile insurance, and they are doing a bigger business, too. These companies selling health insurance are collecting in excess of $2 billion a year in premiums for hospital, medical and surgical coverages. They are at the same time piling up huge reserves.

There is probably nothing wrong with insurance companies selling the nonprofit services of our community hospitals at a profit, although it does prompt a lot of people to raise the question we asked earlier: "What price nonprofit?" Maybe nobody would think of raising the question if hospital costs were so low that the profit added to the nonprofit low cost did not materially affect the ability of the average citizen to secure this coverage. The facts would seem to indicate the contrary. The real trouble is that too many of the coverages offered by some of the commercial carriers are shoddily and pathetically inadequate.

When does a citizen who has paid his money for hospital coverage discover that he has been taken? Usually when he is sick and in the hospital. What are his feelings? You hospital people know the answer to that only too well. Quite frequently he has no alternative but to leave the hospital still owing the hospital a good part of his bill. The citizen who has been taken in this way—and they number hundreds of thousands—is going to feel very strongly about the whole business of financing hospital care, and he is generally not in a mood to be fair to the hospital.

Here again we face the same problem, the same conflict in viewpoints. It is the feeling of so many hospital managements that their business is exclusively to provide the services people need for their care, and that when they deliver these services they have done everything to be expected of them. It is the people's viewpoint that the hospital, as a community institution demanding and receiving special treatment, owes the people more than that.

Certainly, since the major purpose of our voluntary prepayment effort is to preserve our voluntary hospital system, the voluntary hospitals cannot regard the effort with benevolent indifference, not without casting an air of absurdity upon the whole effort. And when a citizen gets stuck with a bad hospitalization policy, it is the whole voluntary effort that suffers. Has the hospital a responsibility in this area?

Let me cite one paragraph from the Imlay City (Mich.) *Times*. Imlay City has a population of 1,141 and is of particular interest to us because it is a rural community. Here is what this paragraph says: "There seems to be no doubt that hospital insurance has become a racket, judging from the number of advertisements that fill our mail boxes."

This is the opinion in the small and rural Imlay City. We would find the same opinion in the urban industrial centers, only very much stronger.

Now to whom can the people turn for advice, for guidance, for leadership, in their efforts to provide themselves with honest and adequate hospital protection? Are not the people making the effort to provide themselves with prepayment the voluntary way in order to preserve our voluntary hospitals? What do the people owe the voluntary hospitals which the latter, by the same token and in the

(Continued on page 156)

How do you describe the

Christmas season in a hospital?

. . . in pediatrics there is brightness and cheer . . .

and perhaps . . . a trace of tears on the pillowcase.

To those who are patients and to those who are on duty,
the hospital is "home". . .

. . . someone
invariably shows up in a
Santa Claus suit . . .

. . . after the visitors are gone and the
carolers have departed . . .
an odd sort of quiet settles over
the hospital.

—pictures by Orlando, Three Lions
—captions by Arnold A. Rivin

California Hospital Association—Incidents and Claims
1954 Policy Year—As of March 31, 1955

	REPORTED INCIDENTS	PER CENT OF TOTAL REPORTED INCIDENTS	CLAIMS RESULTING FROM INCIDENTS	PER CENT OF TOTAL RESULTING CLAIMS	CLAIMS PAID TO DATE	CLAIMS CLOSED WITHOUT PAYMENT	CLAIMS NOW OPEN	CLAIMS OPEN IN LITIGATION
Out of bed—over rails	635	26	32	9	1	29	2	
Out of bed—no rails	366	15	27	8		25		2
Out of bed—ambulatory	648	27	49	14	1	45	1	2
Accidents in bed	188	8	32	9	3	28		1
Surgery & delivery incidents	53	2	32	11		29		3
Medication errors	96	4	14	4	4	10		
Needles lost	23	1	11	3		11		
Sponges lost	18	.6	6	2		6		
Burns	56	2	18	5	1	15	1	1
Equipment accidents	66	3	7	2		6	1	
I. V. infiltrations	35	1	5	1.4		4	1	
Injections—Injuries	11	.4	0	0				
X-ray dept. incidents	9	.4	9	3	2	6		1
Baby identification errors	5	.2	1	.3		1		
Personal property—lost or damaged	10	.4	4	1.2	2	2		
Visitors—slip & fall	113	5	69	20	5	56	6	2
Not classified	86	4	25	7	4	18	3	
	2,418	100	341	100	23	291	15	12

collective action on incidence reports gives California hospitals a

guide to a planned safety program

JAMES E. LUDLAM

FOR THE FIRST TIME in the history of California hospitals, there is now available a collective approach to the accumulation of data on accidents and unusual incidents. The reporting of all incidents by all hospitals, irrespective of the seriousness or possible liability, is considered the key to future success of our new group insurance program. The 120 hospitals now covered under the plan are encouraged in every way to submit reports to add to our growing stockpile of data.

Our group program, as formulated and set up by the Insurance Committee (now Council) of the California Hospital Association, was outlined in the February 1955 issue of HOSPITALS. Basic considerations are that coverage under the plan is adequate, that a sufficient volume of insurance is placed to make it worthwhile for the carrier to furnish a continuous inspection service and maintain interest in the program, that hospitals participate in losses by means of a limited deductible clause as an incentive to keep down losses, and that premiums are realistically related to losses.

It is of utmost importance that the carrier receive all incident reports, so that the experience of a single hospital cannot prejudice the entire program nor upset the balance of premiums against losses. Reserves are not set up against all incidents. Each is individually evaluated, and to date only 7 per cent have led to reserves. Even when a reserve is set up it has no effect on the future premium of an individual hospital, since the premium rates are determined on a group basis. Hence there is every inducement for all hospitals to report all incidents.

The broad experience thus gained is being used as a guide by the Insurance Council, the individual hospitals and the carrier in a planned safety program. The experience of each individual hospital is available to that hospital,

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but more important are the collective statistics which are available to all.

Data and information on the incidents, how the carrier classifies them, why some resulted as paid claims or litigated cases and how the incidents could have been prevented are now being used as the subject of talks given during meetings of hospital administrators, nursing personnel and other employees in the insured hospitals. The general approach is that all hospitals have very similar problems and practices that are producing claims and eventual lawsuits. Exactly which areas and what types of patients are going to produce lawsuits can be determined by analyzing and making use of these over-all statistics. With this information available, the hospitals can then channel their efforts into a safety program using those safety measures that will reduce incidents and in turn reduce the number of eventual claims.

As an example, we can cite the category "Out of Bed—Over the Rails." This type of incident accounted for more than one-quarter of all incidents reported to the insurance carrier by all insured hospitals. A close analysis of this particular category shows that 71 per cent of all patients going "over the rails" do so between 11 p.m. and 7 a.m., 19 per cent from 3 p.m. to 11 p.m. and the remaining 10 per cent from 7 a.m. to 3 p.m. Moreover, 86 per cent of the patients who climbed over the rails or the end of the bed were over 50 years of age; 9 per cent were under 50, and 5 per cent were children.

Even though this group of incidents was one of the largest reported, the resulting claims or litigated cases were exceptionally low.

Such information as the above would indicate that the rails were up on beds of those patients who required such care and that hospital personnel had recognized them as needing some protective measures. The age analysis should point out that rails are generally needed for those patients over 50 and particularly so during the 11 p.m. to 7 a.m. shift. It might also be suggested that the patient received more supervision and care during the day and early evening, and that incidents happened most frequently after the bedtime care, when many patients normally received sedation.

OUT OF BED—NO RAILS

Interestingly enough, this category accounted for only 15 per cent of the total incidents reported. Perhaps this can be attributed to an active program by California hospitals to utilize and make effective standing orders requiring bed rails under specified conditions.

Reports here include patients climbing, rolling and falling out of bed. The reports also cover incidents in which the patient's need for rails was indicated—based on general observation by the nursing personnel—even though the attending physician failed to order rails. As an example, the patient enters the hospital in a somewhat irrational condition. The doctor does not order rails; and 48 hours after admission the patient rolls out of bed, fracturing his hip. Even though the admitting physician did not order bed rails, the facts suggest that the nursing personnel (nine different individuals), having observed the patient over this period, properly should have notified the physician of the patient's condition and put up the rails. This patient, without a doubt, should have been classified by the attending physician at admission as a patient with a special condition and therefore requiring close observation.

Better physician relationships through educating them as to the problems of hospital nursing personnel, admitting procedures and standing orders should help screen these potential problems. Since many of these patients never attempt to call a nurse, reliance on the call button cannot be a complete answer.

The irrational patient is not necessarily within the senile or aged group. A patient of any age can become irrational where such conditions as toxic illness and high temperature exist. In reviewing incidents in this category, our experience is that the age group 50 to 96 years accounts for three-quarters of patients out of bed with no rails in place. Regardless of the age, the sedated patient, the eye patient, the labor patient and the postoperative patient are potential hazards; furthermore, other patients merely reaching for some personal item on a distant night-stand may also roll or climb out of bed. We feel nursing personnel should be constantly reminded that some patients will be reaching for personal items, such as false teeth, cigarettes or eye glasses, rather than calling for the nurse.

This category will produce more actual paid claims and losses than the "over-the-rail" group. Contrary to some general thinking on the bed rail problem, our statistics

MEMBERS OF THE Council on Insurance of the California Hospital Association from the Southern California area discuss incident reports with James E. Ludlam (left), Association counsel and author of this article, and Jack J. Fulton (right), special representative for the insurance carrier. Such conferences represent one phase of the planned safety program to reduce incidents. The Council members, left to right, are Harold Ermshar, Ritz E. Heerman and John P. Preston.

do not prove that patients climbing over the bed rails receive more serious injuries than those rolling out of beds where no rails are in place. Perhaps that rail gives the patient something to steady himself by. As a matter of fact, some administrators who have reviewed these figures with us argue with considerable conviction that they may be an indication of the merits of the half-rail.

We now feel that the ultimate answer to patients-falling-out-of-bed incidents is the electrical multilevel bed; after the doctor and/or nurse have completed treatment, the bed can be returned automatically to its lowest position. Use of this bed may be combined with the half-rail to give an opportunity for safer escape to the patient who will attempt to get out of bed regardless of the type of restraint. This is an expensive answer; but the public relations problem, as well as the liability implications, make the expenditure justifiable. Several hospitals have made the story so poignant that they have interested donors in giving this specific equipment.

OUT OF BED—AMBULATORY

This category breaks down into two distinct groups, attended ambulatory patients and unattended ambulatory patients. This category accounted for 27 per cent of all the reported incidents and at the same time produced less claims but with a larger amount paid out than either the "no rail" or "over the rail" categories. The early ambulation program in California hospitals has caused this type of incident to skyrocket.

ATTENDED AMBULATORY PATIENTS

In many instances, nursing personnel are given orders that read "bathroom privileges with assistance." In most cases, personnel will then assist the patient as ordered, but the written order does not say, "leave the patient unattended part of the time." It implies a possible continuing duty of care; that is, the patient should receive assistance and be attended from the bed to the bathroom and back to the bed. In one incident on file, a patient left unattended for three minutes drowned while taking a bath. The fact that it was necessary for nursing personnel to render any assistance to the patient may have been sufficient notice that the patient should never have been left unattended while out of bed.

The age factor is of utmost importance here, since the elder patients, either medical or surgical, generally will need assistance when they are out of bed. The type of patient is of utmost importance, since this category includes orthopedic patients, patients with heavy casts on their extremities or body, patients using wheel chairs the first time or walking with crutches for the first time. It goes without saying that these patients should be attended and assisted. Nursing personnel should be alerted to the danger that these patients may collapse due to the various contrivances and types of equipment that must be used. Even though orthopedic patients will generally be a small percentage of the ambulatory group, they must be watched closely, at least in the initial stages of ambulation.

UNATTENDED AMBULATORY PATIENTS

Within this group, we find routine postoperative recovery patients and routine medical cases with no serious conditions. Yet once out of bed, these patients may collapse during the first few minutes of ambulation. Even though there may not be specific orders for assisting these people, we feel that it is necessary for nursing personnel to know and observe each patient; his condition may have taken a drastic change from the last time he was seen by the the doctor. Therefore, it is necessary for nursing personnel to recognize changing conditions and anticipate that these changes could cause a routine ambulatory patient to collapse once he is out of bed.

MEDICATION ERRORS

This category accounted for 4 per cent of all incidents reported. Each error in this group could have been fatal. The causes of errors were as follows:

1. Improper Patient Identification. Nearly half of all of the medication errors were directly due to improper identification. It is now felt that asking a patient his name is very dangerous and antiquated, and that the method of identifying by bed tags in crowded hospitals where there is considerable moving of patients' beds is inadequate. It would seem the most positive method for nursing personnel to identify their patients would be some sort of identification attached to the person of the patient from time of admission to discharge. Such a method eliminates the spoken questions and eliminates the possibility of error, should the bed tag be incorrect.

The large number of errors resulting from the improper administration of blood and blood products to patients indicates that every hospital should have written, standing orders on this subject, requiring a double check. The largest claim ever paid by the California program to date fell in this area. Where positive wristband identification has been used on all patients, errors of identification have almost been eliminated. Perhaps the novelty of the experiment contributed to its success, but such a procedure bears serious consideration.

Statistics point out that medication incidents causing injury or inconvenience to the patient or extending the length of stay could be judged in most cases to be acts of negligence on the part of personnel, leading to liability on the part of both nurse and hospital. Human error unfortunately is no defense.

2. Incorrect Dosage. Incidents involving improper dosage have accounted for all remaining identification incidents—55 per cent—and again, a defense is difficult. This type of incident will generally not produce a lawsuit unless the incorrect dosage is serious or fatal to the patient. Many such cases involve additional dosages by nurses on the following shifts. There are cases in which the dosage was incorrectly read, but handwriting being difficult to read is hardly a valid defense.

Here again, it is the function of management to establish procedures and safeguards to avoid errors. A simple requirement that the administering nurse read back the order and dosage works wonders.

Many people in hospital administration are inclined to accept slip and fall accidents as a neces-

sary evil and one of the hazards of running a hospital. This is perhaps true in a certain percentage of cases, but it is not true of all or even most of them. Furthermore, this category, making up just 5 per cent of our reported incidents, gave rise to our greatest number of lawsuits. The fact that some attorneys specialize in trying slip and fall cases indicates the potential loss to hospitals in this regard.

OUTDOOR HAZARDS

Nearly half the slip and fall incidents occurred outside the hospital, and in turn nearly half of these took place right on the threshold or exit. Every hospital entrance or exit should be reviewed with a critical eye—or better still, examined from the standpoint of an 80-year-old rheumatic with bad eyesight. For example, a single step is a claim trap; use a ramp. There should be a rail down each side of a set of stairs and one down the middle if the span is wide. Take added precautions if the patient must look into the sun. Be sure stairs and walks have a nonskid surface, whether wet or dry. Check your sprinklers to see that they do not wet or muddy your walks.

PARKING LOT HAZARDS

A new hazard is the parking lot. If it is not cleaned frequently, foreign material will collect and grease accumulate. Many visitors use the lot at night. If the lighting is from the hospital building, it may shine directly into the eyes of a person approaching the hospital; they may stumble over curbs, sprinklers, parking guards and the like. Two-fifths of our outside slip and fall cases were in the parking lot.

As might be expected, 58 per cent of our inside slip and fall cases were in the corridors. In a majority of these cases the waxed floors were too slippery. Every hospital should periodically check its floors for slipperiness — all floors, because it is amazing how the floors in an individual hospital will vary. It is possible to reduce this hazard.

It does no good to keep the floor well waxed if liquids or foreign substances are permitted to col-

robot blood counters

THE INTERN'S DREAM seems about to be realized at last. A Boston company has announced that an automatic and electronic blood counter is now available. Designed by Doctors Richardson, Diamond and Breck of Boston, the new gadget makes and records a complete blood count in less than two minutes.

You put a drop of blood in a counting chamber and press some buttons. A built-in microscope with a built-in dark field forms an image of the cells and transmits the image to a built-in photomultiplier. A light beam scans the cells and registers the leucocytes or the erythrocytes or both, as predetermined by a selector switch. This then feeds its results into a "computer circuit." The count is displayed on a calibrated large dial, all ready for report without further conversion or calculation. Accuracy? Plus or minus three per cent.

First they invented the sphygmomanometer. In my father's generation, they scorned M.D.s who couldn't estimate blood pressure by feeling the radial artery and who had to depend on machinery. Before that, someone invented a glass tube that registered body temperature and took away the satisfaction of the practitioner who could estimate body temperature within 0.5 degrees just by feeling the forehead. If we trace it back far enough, the culprit who started this destruction of *ars medicinae* was the one who invented the clock (its first use was pulse counting, by the way) and deflated the doctors who could estimate pulse rate by touch.

So now comes the "arithmometer" for counting blood cells. Any day now the electrocardiogram will have a word-writing stylus built in that will write the diagnosis as well as the curve. Electroencephalography will come next, as they discover the special signature of each neurologic syndrome. Surely there should be something better than boiling for albuminuria. We look for a gadget that will accept the urine, smell it, taste it (for the honey taste in diabetes), measure its acidity and albumin content and then by ringing bells or stylus-writing come up with a diagnosis.

By the next century the doctor's bag will have no stethoscope, sphygmomanometer, percussion hammer or tongue depressor in it. No, all he will need will be a wrench, a pair of pliers and an oil can to keep the machinery in good order.—*Editorial, from* The Journal of The Medical Society of New Jersey *(51:12), December 1954.* ■

lect on the floor. A good safety rule is that no one is too good to clean up a wet spot or stand guard until it is cleaned.

Stairways constitute another hazard zone. Here again, lack of proper maintenance or failure to use protective pads or abrasive strips was indicated.

The patients' rooms contributed 15 per cent of the inside fall cases. We have the problem of liquids and foreign matter on the floor, with the additional hazard of falling over equipment. Constant maintenance is the best if not the complete answer.

EQUIPMENT AND SUPPLY ACCIDENTS

This group generally involves faulty equipment or faulty installation, which can generally be said to be the result of direct negligence of the hospitals. In some instances, the supplies and equipment are defective or hazardous, and the manufacturer might be held partially liable; but the hospital will escape liability only with difficulty. If the hospital has an incident resulting from defective equipment, it is of utmost importance to immediately isolate that piece of equipment, as it may be a vital piece of evidence. It should only be released on instruction of the hospital attorney or insurance carrier. Not even the manufacturer should be permitted to have possession of it without this clearance; the hospital may find the item is needed in proving its right to charge the manufacturer or supplier with responsibility for the incident. There have been a number of serious cases where the manufacturer has assumed the full cost of defense as well as liability for loss.

Unfortunately, some of the worst accidents have resulted from new equipment. These have developed either from a failure to evaluate properly the potential hazards created by the new equipment or from failure to utilize it properly. Too much reliance can be placed upon the Underwriter's Laboratory approved label. This label means that the equipment is properly constructed and has passed a wiring inspection but does not mean that it is foolproof.

A constructive approach to this problem is appointment or election of an equipment committee within the hospital charged with the selection and final inspection of all new equipment. This committee should include the administrator, engineer, purchasing agent and such department heads as may be directly concerned with the particular equipment being considered. All equipment should be bought subject to final approval by actual inspection of the committee. The committee should concern itself with all possible hazards, such as:

(a) Whether electrical equipment is grounded by a three-wire connection. This is essential to prevent a serious shock. Often, hands of patients or nurses are moist, and they may take a terrific jolt. Hospitals should insist on three-wire cords not only on equipment in patients' rooms but even in the kitchen and in offices.

(b) Whether thermostatic-controlled equipment has a maximum heat limiting device. If the unit is not heat-limited, then it must have a time-limit control. This is particularly important on all bed-heating equipment.

(c) Whether electrically operated incubators, even the latest models, have been studied for potential hazards by assuming they may not be properly utilized during an emergency; for example, the need for using an incubator for more than one baby. Several serious accidents have occurred in what was thought to be the most advanced type of incubators.

(d) Whether operating instructions are clear and simple. If they are not, rewrite them. A student nurse is not a mechanic.

(e) Whether equipment allows possible patient involvement. Can a delirious patient overturn the equipment or pull it down on himself? Can bandages be ignited?

These are illustrations of hazards generally related to electrical units. There are other areas of great concern. For example, bed rails and traction devices should be checked to make sure they have a positive lock even when put together carelessly. Many accidents have resulted from failure of this type of equipment, and all such items should be subject to a periodic inspection.

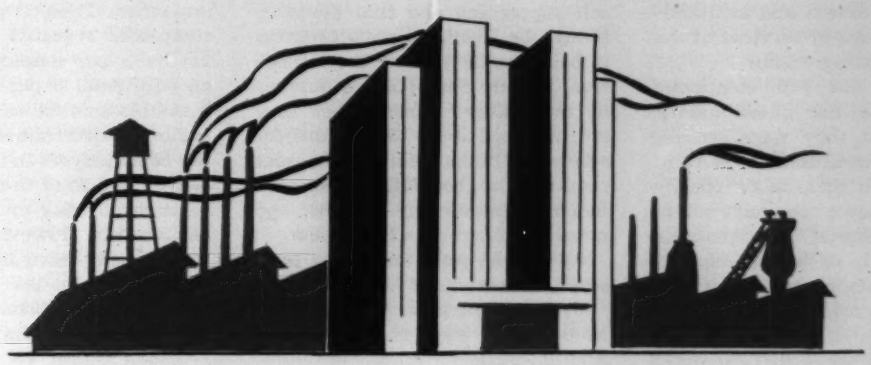
There are other smaller groups of accidents that bear brief notice:

1. Burns. This includes hot water bottle accidents and those involving heating pads, therapy lamps and hot liquids spilled on the patient. They are generally looked on as direct negligence of the personnel, since the object causing the burn is under direct control of a hospital employee. The practice of doing away with all hot water bottles is gaining wider acceptance.

2. Lost Sponges and Needles. This category is well down in the list in frequency, but each incident carries a long fuse, the statute of limitations not applying until the patient discovers the incident. Here is an area in which the responsibility or the lack thereof should be clearly defined. If hospital personnel are not making either sponge or needle counts, this procedure should be clearly understood by all concerned, particularly by the surgeons, who must then assume full responsibility.

3. Baby Identification Errors. This is also near the bottom in frequency; but each error is not only a professional liability problem, it is a tremendous public relations problem. Positive identification through the wristband method with the mother participating in removal of the band on discharge, together with a written acknowledgment, appears to be the safest method.

We owe a debt of gratitude to hospitals participating in the California program for their effective coöperation in making these incident reports available whether liability was indicated or not. It is through this continuing accumulation of statistical information that we will be able to get to the heart of a claims prevention program. Incidents which do not take a pattern in a single hospital do so when classified with those of more than a hundred hospitals. As trends develop they are discussed with nursing personnel, who are directly involved in four-fifths of the reported incidents. They are eager to help, only needing guidance. The program can furnish the information, but leadership and the ultimate solution of our problems must come from hospital administration. ■



corporate contributions to hospitals

DONATIONS TO hospitals have become a major item in the philanthropic budgets of American business corporations and appear likely to assume even greater importance in the near future. Most companies recognize that they have a community responsibility to support worthy hospital drives and gladly contribute what they regard as their fair share. However, according to answers returned by 179 companies to a recent National Better Business Bureau questionnaire, there is much uncertainty as to what industry's fair share of hospital giving should be. There is little or no uniformity among corporations as to criteria applied in determining that amount in specific cases.

Ninety-four per cent of the participants in the survey gave to hospitals during 1953, or their next fiscal year . . . Seventy-one per cent reported contributing to hospital *operating* budgets during the past year or so and 75 per cent have contributed to *capital* funds for new buildings, modernization, expansion etc. . .

The full amount of the contributions of these 179 companies cannot be calculated because one of the unexpected facts encountered in the survey was that many corporations do not know how much they have been giving to hospitals. For example, 75 companies reported contributing to hospital operating budgets through Community Chests or United Funds. Little more than a third (28) knew what percentage of these contributions was allotted to hospitals . . .

The benefits which may logically be expected to flow to employees as the result of a company donation is a factor of paramount importance in corporate giving to hospitals . . . Hospital and surgical insurance is of doubtful value to the employee for whom no hospital bed is readily available . . . Although this survey did not include expenditures for employee insurance protection in computing hospital donations, some participants suggested that these fringe benefits are, in a sense, an important corporate contribution toward hospital maintenance.

. . . Of 169 companies answering the question, "Where are the hospitals located which you supported in the past year or two?", 64 per cent stated that they contribute to hospitals in the immediate vicinity of their plants or office installations; 40 per cent give to hospitals adjacent to their plants where a concentration of their employees may live; and 16 per cent contribute in areas where they have a relatively small operation, such as a sales office with a few employees.

. . . One out of five companies participating in this survey, reported that they have no definite policy which determines whether an appeal for a contribution will be granted.

Of those having a policy 77

"Corporate Contributions to Hospitals" is the first survey to be conducted by the National Better Business Bureau in coöperation with its Solicitations Panel. The Panel is presently composed of representatives of 262 large, small and medium-sized business firms constituting a cross-section of American industry. It was organized by the Bureau to provide business executives with a vehicle for the exchange of information and views on corporate giving problems of major significance.

This first subject for study was selected by the Bureau's business Advisory Committee on Solicitations in the belief that there was widespread need of, and eagerness for, information on this subject by business firms. The results have amply justified this belief. A remarkably high 70 per cent of panel members returned complete and compilable questionnaires, in the preparation and compilation of which, the Bureau was professionally assisted by Stewart, Dougall and Associates, New York research and consulting firm.

This article has been abstracted from 'Corporate Contributions to Hospitals,' a copyrighted publication of the National Better Business Bureau, Inc. The full report and supplement are available from National Better Business Bureau, Inc., Chrysler Building, New York 17, for $2.50.

companies . . . stated that it was based on the extent and availability to employees of services of the hospital soliciting funds.

Many of the 179 companies responding to the questionnaire, indicated that they were seeking to develop a formula for determining industry's and, more specifically, their own company's fair share of hospital contributions. However, 171, or 94 per cent of all respondents, reported that they have no such formula at the present time.

. . . What we have attempted to do is to assemble and report the actual practices of a representative group of business corporations . . . With this in mind, the study sought to answer two main questions:

1) *What criteria do corporations employ in deciding whether to support a given hospital appeal?*

2) *How do corporations determine how much they will give to a particular appeal?*

FACTORS AFFECTING DECISION TO GIVE

1) Availability to employees of the services of the hospital soliciting funds.

Most corporations believe that the hospital should benefit employees and be used by employees. For this reason . . . most corporations confine their contributions to areas where they have plants, distributing branches or other important operations and, secondarily, to areas in which substantial numbers of employees and their dependents live . . .

2) The need for help must be established.

Conditions in the community must be such as to justify building new hospitals or expanding or improving old ones.

3) The hospital facilities must be available to all, benefiting the entire community.

Many corporations will not contribute to hospitals which practice discrimination as to race, color or creed although they have no objection to the operation of a hospital by a religious or sectarian order.

4) The hospital must be efficiently operated.

Several companies expressed the view that a primary objective of the hospital should be to become self-supporting and that evidence should be available that progress is being made toward that objective. In this connection, a number of companies reported that they will not contribute to hospitals for operating funds. Many companies require that hospitals submit financial statements, budgets and other pertinent data for review . . .

5) The hospital must be a nonprofit, tax-exempt organization.

6) The hospital must have broad public support and community interest.

The citizens sponsoring the drive and board of trustees or other governing body, should be representative of community leaders and participate actively in policy decisions.

7) The hospital must be duly accredited and its medical staff recognized as competent.

Specific questions asked are:

"Is the hospital accredited by the Joint Commission on Accreditation of Hospitals or does it have a reasonable prospect of accreditation when the building project for which funds are solicited is completed?"

"Does the hospital provide diagnostic and treatment facilities consistent with the minimum standards outlined by the Federal Hospital Construction Program?"

8) Many companies reported that they restrict their contributions to general hospitals.

However, there are a few who, because of the nature of their business, donate to certain specialized institutions.

9) The gift must advance the community and public relations programs of the company.

Hospital donations are regarded as expressing industry's faith in voluntary coöperation in dealing with community problems in a voluntary way . . .

Many companies rely on the recommendation of plant managers but will integrate the suggested amount of a contribution into the parent company's budget operations to determine ability to pay . . .

HOW ARE AMOUNTS DETERMINED?

The number of employees, particularly in relation to the employed population of the community as a whole, is the yardstick mentioned more frequently than any other. Thus, 31 per cent of the companies reported they contribute on a per employee basis and an additional 8 per cent reported that the amount of their contributions is determined by the number of employees in the area served or by the size of their company in relation to that of others in the community. However, most companies using this yardstick pointed out that while the per employee basis is an important factor, it is not the only one that they employ.

Contributions on a percentage basis of the total campaign goal were reported by 17 per cent of the companies . . . Many of the companies advise that they contribute the same percentage as their proportion of Community Chests . . .

FORMULAE

. . . The most specific of the formulae whereby a company undertakes to determine its fair share of hospital contributions are as follows:

$$\frac{a \times b}{c} \times \frac{d}{2} = \text{company's fair share}$$

$$\frac{a}{c} \times \frac{d}{2} = \text{company's fair share}$$

Legend for the two foregoing formulae:

a. *Number of company employees in the area served.*

b. *Average sized family per employee.*

c. *Population of area served.*

d. *Amount of campaign goal.*

Another company reported that the following factors are given consideration in determining its contributions:

—The population of the area to be served by the hospital facility and the percentage of employees and their families in the area population.

—The present and contemplated beds per thousand population compared with what we believe to be a desirable average of about 4½ beds per thousand population.

—The average cost per bed compared with the national average of approximately $15,000 to $17,000 per bed.

—The amount of the goal and the gifts of subscriptions by other

firms, both local and those with headquarters elsewhere.

Total days of care given employees by the hospital is the sole yardstick applied by four participants in the survey and by 8 per cent of all participants . . .

—Number of employees served on basis 25 per bed year. Per cent of 25 times $16,000 per bed.

—Based on number of bed-days and multiplied by a factor to determine the number of dollars which we consider to be our fair share.

—Employee use factor as computed by the hospital. (Number of company patients and patient-days utilized.)

—Because of multiple hospitals serving our area, we consider this as a second factor (to per cent of total campaign goal)—particularly in rural areas—in making minor adjustments that appear equitable.

Other yardsticks applied are listed as follows in the frequency of mention.

—A percentage of the company's total annual philanthropic contributions.

—Recommendations by local management and others.

—Need for the project.

—Size of contributions made by other companies.

—Size and importance of company in community.

—Amount of contributions by employees . . .

Several companies reported that subjective factors influenced their decisions and 16 per cent of all contributors indicated that they employed no specific yardsticks but made their decisions on a more or less arbitrary basis. Some have expressed doubt that any exact formula for corporate giving to hospitals is practical . . . one company states:

—". . . It has found through long experience a hard and fast rule did not have the same implication in each of the more than 100 cities in which the company has installations . . ."

Another company . . . stated . . .

—". . . Contributions should meet three standards:

—"It is to the company's interest to support the cause.

—The organization receiving the money will effectively further the cause.

—The amount given represents the company's fair share of the obligation."

Critical notes were voiced by some participants . . . :

—"The main fault which I find with some appeals, particularly those related to capital fund campaigns, is that an attempt is made to thrust upon corporations the entire burden . . ."

Another company stated:

—"Hospitals suffer from institutional egotism—too often plan, practice, operation, facilities needs from the base of pet ideas, appetites and peculiar—versus general —interests . . . too frequently the trustees, who might help with realism, are divorced from basic decisions and are used merely as fund-raising fronts . . ." ■

Should I become a nurse?

A hospital-high school program helps Tunica, Miss. teenagers to get better acquainted with the nursing profession.

MURRAY E. HILL

EVEN BEFORE THE opening of 25-bed Tunica County Hospital in the fall of 1950, we found ourselves in a quandary over personnel recruitment. Tunica, in the rich delta country in northwestern Mississippi, posed a somewhat unique situation in this regard. There were no hospital personnel of any type to be found in our community. The initial staff and all subsequent replacements would have to be brought in from outside. This also would make it quite difficult for us to maintain needed personnel.

We found, furthermore, that 75 per cent of all local high school graduates immediately entered college. The others neither seemed interested nor had the right qualifications for hospital work. Despite this, our local high school authorities and the hospital administration worked closely over a four-year period to encourage interest in the hospital among the students, both male and female.

From this, a plan developed whereby senior girls can take a one-year course in nursing for which they are given actual high school credit toward graduation. Two hours of classroom work one week are followed the next week by two hours of actual hospital instruction. A special uniform can be worn in the classroom and the hospital. A teacher is furnished by the hospital—an experienced registered nurse with the ability to make both classroom and demonstration work interesting. The curriculum is based on *The Handbook for Nursing Aides in Hospitals*, obtained from the American Hospital Association; we have found this ideal for our needs.

Each quarter, the girls are tested on their work. These tests are graded and marked as if the course were a school subject handled exclusively by the school. After the final examination, there is a special "capping" ceremony where graduates receive a pin and an insignia —"Nursing Assistant"—to be worn on the left arm of their uniforms.

In organizing the course, we had decided first to explain its purpose to girls in the upper two grades, since we felt so few would volunteer. Response was so great, however, that the course had to be limited to seniors. We note with pleasure that all this "volunteering" has been from a group of students whom we had been unable to interest in nursing during the previous four years.

We hope, on graduation, that many of these girls will take up nursing as a career. Nevertheless, even those who don't will have had a year's training, perhaps to be available to us as nursing aides and attendants.

While it is yet too early for us to really know the success of the program, our educators and the hospital authorities think so well of the program that we expect to continue it for the years to come. ■

Mr. Hill is administrator of the 25-bed Tunica County Hospital, Tunica, Miss.

how to select an *auditor*

BEFORE DISCUSSING THE selection of an auditor, it may be well first to consider the reasons for having an independent audit.

Business concerns have independent audits to provide a reliable picture of the financial position and operations of the company for the management, stockholders (or owners), creditors and other interested parties. These reasons also apply in the case of proprietary hospitals.

For nonprofit hospitals which solicit funds from the public independent audits have the additional value of assuring the public that the management's use of its contributions is properly reported. This has become increasingly important in recent years, when hospital rates have gone up as the inevitable result of rising costs.

The end result of an audit is the auditor's report, accompanied by financial statements. The financial statements themselves are of course the responsibility of management, whether actually prepared by management or by the accountant from information supplied to him. The auditor's report gives the accountant's professional opinion as to the fairness with which these statements present the financial position and results of operations.

The value of the audit report naturally depends on the accountant who prepares it. The significance of the opinion expressed depends entirely upon his professional qualifications—his competence, independence and integrity.

ACCOUNTANT'S ADVICE

These qualities are also important in connection with the accountant's role in advising management on accounting systems and procedures. Either in his report, or by separate communication, he usually makes suggestions for improvements in the hospital's internal accounting methods. The value of these suggestions will depend on the professional skill and experience of the auditor.

Now, what guides are there to

This article was prepared by the American Institute of Accountants, the national professional society of certified public accountants.

Excerpts from the Rules of Professional Conduct of the American Institute of Accountants

(5) In expressing an opinion on representations in financial statements which he has examined, a member may be held guilty of an act discreditable to the profession if

(a) he fails to disclose a material fact known to him which is not disclosed in the financial statements but disclosure of which is necessary to make the financial statements not misleading; or

(b) he fails to report any material misstatement known to him to appear in the financial statement; or

(c) he is materially negligent in the conduct of his examination or in making his report thereon; or

(d) he fails to acquire sufficient information to warrant expression of an opinion, or his exceptions are sufficiently material to negate the expression of an opinion; or

(e) he fails to direct attention to any material departure from generally accepted accounting principles or to disclose any material omission of generally accepted auditing procedure applicable in the circumstances.

* * * * * * * * * * *

(10) A member shall not advertise his professional attainments or services . . .

* * * * * * * * * * *

(14) A member shall not make a competitive bid for professional engagements in any state, territory, or the District of Columbia, if such a bid would constitute a violation of any rule of the recognized society of certified public accountants or the official board of accountancy in that state, territory, or District.

* * * * * * * * * * *

(16) A member shall not violate the confidential relationship between himself and his client.

help in selecting an auditor? Normally, he will be appointed by the board of trustees, but the hospital administration may be asked for suggestions. Here are some points to consider:

Certified Public Accountant: If you choose a certified public accountant as your auditor, you have the assurance that he has met educational and experience requirements to the satisfaction of your state board of accountancy. All states now use a uniform certified public accounting examination designed to maintain the high standards of the accounting profession.

Good Local Reputation: Since an important reason for the audit is to maintain public confidence, it is desirable that the auditor have a reputation in the community which will inspire confidence in the opinion expressed.

Familiarity with Hospital Accounting: An auditor who is experienced in hospital auditing will naturally find it easier to understand your hospital's problems and procedures. From his knowledge of methods used in other hospitals, he may be able to make more helpful suggestions for improvement of your accounting system. However, lack of prior hospital experience should not preclude the engagement of a particular certified public accountant, because wide experience in auditing and acting in an advisory capacity to a variety of businesses enables him to provide effective service to a hospital.

Recommendations: The recommendations of bankers, lawyers, businessmen and other accountants will help you to select your auditor.

Professional Activity: Membership and active participation in professional accounting societies should be taken into consideration as an indication that the accountant is keeping abreast of his rapidly developing profession.

Scope of the Audit: Don't "shop around" for the lowest bid. Competitive bidding on audits is discouraged, even in the case of governmental agencies, as an unsuitable method of obtaining professional services. It is important that the scope of the audit not be restricted. The auditor should have as much latitude as may be necessary for him to be assured that the records are in order and that the system of accounts is functioning properly.

The cost of the audit is far from the most important factor in selecting the auditor. However, after satisfying yourself as to the qualifications of the auditor, it is usually helpful to discuss the basis of billing for services. The accountant may be able to estimate the cost of the audit assuming normal conditions. If unforeseen problems require additional work, it is obvious that the very purpose of the audit would be defeated unless the scope of the auditor's engagement is broad enough to cover them. ■

administrators guide issue | *errata*

The following errors in the 1955 Administrators Guide Issue of HOSPITALS (Part II, August 1955) have come to our attention. Please correct your copy accordingly.

HOSPITAL—STATISTICS

Page

17 Special note on table 9. Second paragraph should read: "The 'Other Federal' category includes," etc.

52 Column 1, second paragraph, line 7. Change "107 per cent" to "94 per cent."

57 Column 3, first paragraph. Last sentence should read: "As the accompanying tabulation shows, more than 90 per cent of all short-term nonprofit general hospitals," etc.

LISTING OF HOSPITALS

Provisional Accreditation—The following hospital should have the code number 2 added to the "Approvals" column, indicating its provisional accreditation by the Joint Commission on Accreditation of Hospitals:

Page **Florida**

134 Coral Gables: Doctor's Hospital

Full Accreditation—The following should have the code number 1 added to the "Approvals" column, indicating their full accreditation by the Joint Commission on Accreditation of Hospitals:

Page **Florida**

134 Clearwater: Morton F. Plant Hospital
135 Jacksonville: Brewster Hospital
Duval Medical Center
Hope Haven Hospital
Riverside Hospital
St. Luke's Hospital
Lakeland: Morrell Memorial Hospital
Miami: Variety Children's Hospital
Miami Beach: St. Francis Hospital
136 Pensacola: Sacred Heart Hospital
137 Tallahassee: W. T. Edwards Tuberculosis Hospital
West Palm Beach: St. Mary's Hospital

Minnesota

197 Minneapolis: Swedish Hospital

New Mexico

222 Los Alamos: Los Alamos Medical Center

American Hospital Association Membership. The following hospital should have a star (*) preceding its name to indicate its membership in the American Hospital Association:

Missouri

Page

207 St. Louis: St. John's Hospital

Hospital Councils—In the material prefatory to the hospital listing the following change should be made:

Pennsylvania

Page

259 Line 7 of column 2 should read: "Hospital Councils: Allentown Hospital Association," etc.

NURSING SCHOOLS

The following professional nursing school should be added:

Page

431 New Jersey, Trenton: William McKinley Memorial Hospital
Practical Nursing Schools

The following practical nursing school should be added:

Page

434 Minnesota, Winona: Winona School of Practical Nursing

the need and importance of

a health program for employees

HELEN REISCHL, R.N.

THE HIGH COST OF accidents has been impressing itself on hospitals all over the United States through increasing workmen's compensation costs.

A good portion of the rise in cost stems directly from the increased accident rate, and the rate is still on the rise except where planned and thorough prevention programs have been put into effect.

One aspect of such a prevention program is the health program for hospital employees. Loss prevention, in any prevention program, must of necessity include health promotion and health maintenance. Health and safety are, and always have been, interrelated. No one can deny that a healthy employee is a safer employee.

To get to the grass roots of the hospital problem, look back to what has happened the past ten years. Employment in the majority of the hospitals has doubled and, in many instances, tripled. The labor market, on the whole, has been tight. Hospitals have not generally been able to pay the prevailing wages of the industrial and business enterprises in the community. Therefore, some persons turned down by business and industry for various reasons—physical defects, age, semi-invalidism, lack of skills—have sought and been given employment in hospitals. Besides a tight labor market, the problem of turnover has weighed heavily on hospital administration. Perhaps, the latter problem more than any other, coupled with the shortage of professional personnel, has hindered the adoption of up-to-date occupational health principles.

In many hospitals, the prospective employee may or may not have been given a physical examination before being hired. But even if he or she did have a physical examination, in many instances the results of the examination were filed and the employee was put to work. With little orientation and with little thought to placement according to physical abilities, the employee was expected to function satisfactorily in the productive scheme of the hospital.

If an employee was injured, or became ill on the job, the treatment was absorbed in the routine function of the hospital. Some were treated on the ward, others sent to the outpatient department or emergency ward. If the injury was serious and lost time was involved, records to the insurance carrier were made out by someone in the office. When the employee returned to work, he resumed his past job. No one person in the hospital organization followed through the injury from time of occurrence to return to work. Could the injury have been prevented?—Was it a repeat accident?—Was it human failure? Are the physical defects found on the physical examination record a contributing factor?—Is the individual's social background—worries, frustration, fears, illness at home—in some way responsible? These are only a few of the many problems.

More and more hospitals are adopting personnel activities designed, not as a substitute for higher wages, but rather as an inducement for new employees and those already at work. In many areas, hospitals are looking to business and industry and duplicating their methods. They are also glancing into the field of human relations, where human and economic factors are considered, both of which have proved to be profitable.

The "Three Musketeers" of human relations, personnel, health and safety, have identical goals—the improvement of human relations through the advancement of happiness, health, and safety.

Again, looking to business and industry for motives to carry out this triumvirate, we find that accident prevention has been the motivating principle behind the adoption of most health programs. However, it is no secret that health programs have paid dividends besides reduction in accidents. Im-

Miss Reischl, an occupational health nursing consultant to Employers Mutual Liability Insurance Company of Wisconsin, gave this paper at a Safety Institute sponsored by the Wisconsin Hospital Association in Milwaukee last December.

proved employee health, improved morale, reduction in absenteeism are now recognized benefits.

There is no custom-made medical and health program which suits the requirements of all hospitals. But no hospital is too large or too small to carry out the objectives of a sound health program, namely:

1. To ascertain, by physical examination, the physical and mental fitness of employees for the work they are to carry out.
2. To assist in maintaining and improving the health and efficiency of those already employed.
3. To detect communicable diseases, chronic illnesses and old injuries which might be exploited by unscrupulous employees.
4. To educate the worker in matters of health and personal hygiene.
5. To reduce lost time and absenteeism from illness and/or injury.

To carry out these objectives in the hospital, the following are necessary:

1. An organized plan for medical and health services.
2. A qualified staff (doctors and nurses).
3. Adequate dispensary facilities.
4. Adequate cumulative health and accident records.

AN ORGANIZED PLAN

The pre-placement physical examination, including chest x-ray, is the cornerstone of any hospital health program. The object is not to screen out imperfect specimens, but to assign employees to work which presents little accident or health risk for them or the patient.

For example, several years ago, a Wisconsin hospital hired an aged woman for kitchen help. This woman wore a steel back brace because of a severe arthritic condition. Without physical examination, she went to work. During a noon hour, carrying a tray, she slipped. She became permanently disabled as the result of a back injury, and will receive compensation for the remainder of her life.

Another hospital hired a graduate registered nurse, without giving her the pre-entrance chest x-ray. After two years of employment, she was found to have a far advanced pulmonary tuberculosis. No one was ever able to determine exactly whether this condition existed at the time of employment or whether it was acquired in the hospital.

In many states, contagious diseases, including tuberculosis, might be compensable if it can be proved that the employee acquired them while at work. Hospitals need to screen all patients on admission by means of chest x-ray to protect employees. They also need to periodically screen employees by means of chest x-ray for their own protection and that of the patients with whom they come in contact.

The physical examination appraisal or classification is being used more and more as an employment guide. The doctor grades applicants on a five-point scale. At the top are those suitable for any type of work. At the bottom are those who should not be hired. In between are those who require special consideration for placement. The physical examination results for each employee are then correctly interpreted to the personnel department where the physical capacities are matched to the job requirements.

QUALIFIED STAFF

In the larger hospital, the principles of occupational health can be carried out in a well equipped health service unit. A qualified registered nurse, working under the direction of a health service physician administrates this department. Here, all employees report their accidents and illnesses. The results of the physical examination are discussed with the prospective employee, by this staff, and defects found are urged to be corrected. All follow-up on health and accident matters should take place here as well as the start of safety education. Post-absence counseling belongs in this department, where some one person is interested in the employee's health and welfare.

The health service nurse may also administer the health program for student nurses. Many nursing schools are using their health service as an ideal teaching situation where the students spend some time on a rotation basis for the purpose of observing occupational health nursing. A nurse with some public health background, or a background of occupational health nursing, functions ideally in this position.

For the smaller hospitals, the principle of centralizing a health service needs to be retained. A part-time physician and nurse can carry out an organized plan for physical examinations, caring for minor illnesses and injuries, and health counseling by providing time each day for this service.

ADEQUATE DISPENSARY

A health service in a hospital should be a separate unit so that when injury or illness occurs, it does not upset the normal routine on the wards but channels into one department the problems encountered. How large or small the dispensary facilities should be depends entirely on the size of the hospital and number employed.

The record system should include cumulative health and accident records. They not only become valuable in health and accident appraisal, but also are excellent tools for guidance and counseling.

The record system may include all group insurance records as well as all compensation records. Employee group insurance claims, with diagnosis, should be channeled through this department for the purpose of completing the health record. Absentee records may also be kept in this department for the purpose of correlating the health and safety program. Accident records should be analyzed periodically by the safety organization. The nurse in charge of the health service is an active member of this organization.

These health objectives and the means of carrying them out have worked for business and industry; they should work for hospitals. Occupational health nursing has paid for itself over and over again in the business field. Hospitals are in an advantageous position to provide health service to their employees. The very nature of hospital work should provide the impetus needed to develop comprehensive health coverage. Healthy workers contribute both directly and indirectly to efficient patient care. They also are an asset to any safety campaign. ■

your president reports

ONE OF THE HIGHLIGHTS of my October activities as President was a conference that J. Douglas Colman, Dr. Crosby, Kenneth Williamson and I had with Marion B. Folsom, the new Secretary of Health, Education and Welfare. The Association requested the conference in Mr. Folsom's Washington Office for the purpose of stating the Association's position on several of the major bills that Congress will probably consider when it reconvenes.

The great amount of hard work done by Dr. Lucius Wilson and his Council on Governmental Relations in developing statements of principles on the several important health problems really proved useful during the conference. Those carefully thought-out statements not only permitted us to express the Association's position clearly, but they also served to brief Mr. Folsom's assistants prior to the conference. The two hours allotted for our meeting with Mr. Folsom and his assistants would have permitted little more than a courtesy visit if that briefing had not already been accomplished.

Those of you who have not visited the Association's Washington Office should do so whenever you have occasion to be in that city. It is a bee-hive of activity and serves to remind one of the tremendous influences that federal legislation and federal agencies have on the hospital and health fields.

One of the major tasks of the Washington Office is researching facts as a basis for policy decisions by the Association, and for use in presenting testimony on proposed legislation. The necessary facts are not always easy to come by and numerous sources often have to be checked.

Another interesting activity during this month was the three day session of all the Councils of the Association, including the Committee on Auxiliaries and the Executive Committee of the Blue Cross Commission held in Chicago. This was the third year the Association has brought all its Councils together for their initial meetings following the annual convention.

This joint meeting serves to orient the members of each council to the work of all the other councils. The Association, like the hospitals it represents, is a complex organization with many diverse activities and all parts need to be dovetailed into the full program.

The first day is given over to orientation of the new members of the councils but they aren't the only ones who have skull practice. Some questions asked by new members required a little hard thinking by the officers and staff before replies were given.

It was my pleasure to participate on the program of the Nebraska Hospital Association's annual meeting in Lincoln during October. The achievements of that association during the past year, under the leadership of Herbert Anderson as president and Stuart Mount as executive secretary, are numerous and significant.

It demonstrates again the values of a full-time executive to a state association. Hospital administrators carry too heavy a schedule on their own jobs to permit them to develop the details of their state association program and to give the necessary follow-up to the various activities the association should be conducting. Also, I doubt that hospital administrators are as skilled as experienced association executives in handling many aspects of the association's work. The position of association executive seems well on its way to developing into a profession utilizing skills, techniques and knowledges uniquely its own. This budding profession is not, of course, restricted to the hospital field, but is involved in about every form of professional and economic activity. As might be expected, there is a national association of association executives.

Our state hospital associations play a vital role in hospital affairs. This role will become increasingly important as the program of the American Hospital Association expands. For many reasons the state association is the logical vehicle through which much of our national association's program will have to be implemented. Because it is close to the local hospital's problems it can best determine the emphasis to be given various activities at any given time; or the best manner by which to adapt material developed at the national level for use in the hospitals of a particular state; and can exert an influence to assure that the fullest possible use is made of such material.

The most important function of the state association will remain, however, the provision of those services which can best be provided at the state level. There are many problems peculiar to the individual states on which a national association simply cannot give effective help. If hospitals are to continue to improve the quality and efficiency of patient care, and to effectively meet the increasingly difficult problems which confront them, they must have strong associations at both the national and state levels. Neither can adequately function without the other.

Ray E. Brown

Ray E. Brown, president
American Hospital Association

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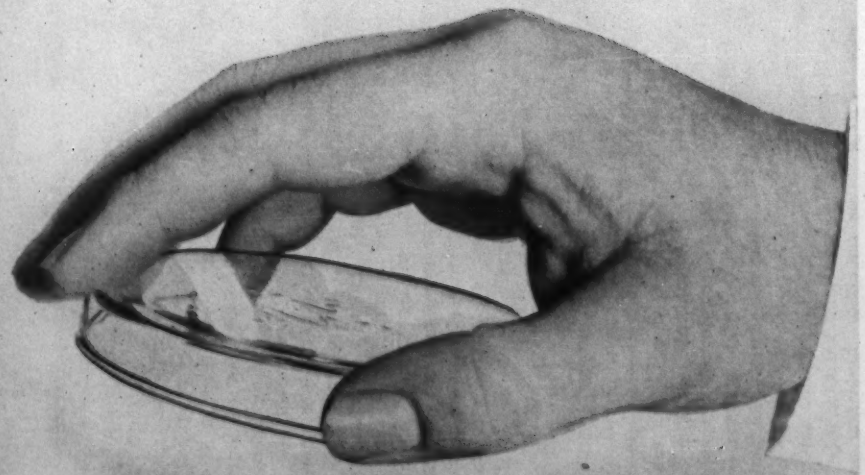

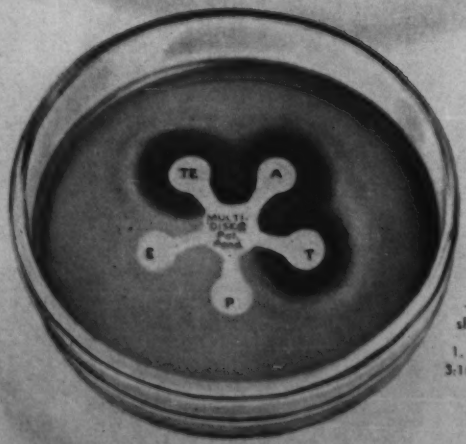

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This sensitivity test shows ERYTHROCIN and the same antibiotics against a typical intestinal strain of *E. coli*. Note that ERYTHROCIN and penicillin do not affect this gram-negative organism —although the other antibiotics show marked inhibitory action.

1. Eisenberg, et al., Antib. & Chemo., 3:1026-1028, Oct., 1953.

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509183

medical review

A New York rural hospital reports mounting evidence of its success in—

launching a physiotherapy department

ROBERT A. ANDERSON

THE EXPERIENCE of 117-bed Wyoming County Community Hospital in establishing a fully organized department of physical medicine may be of value to other hospitals which have not yet taken this important step. The fact that this hospital is located in a rural area sheds light on the ability of such a department to thrive under marginal conditions.

Other problems involved were universal: the degree of medical direction and participation, the selection of personnel, the referral policies, the space required and the types of equipment needed to get started. Thoughtful attention to all such details before the announcements are mailed out results in a smoothly functioning service.

The success of the new department, while gratifying, has accentuated the void which preceded it. Failure of a hospital and its staff physicians to exploit the potentialities of physical medicine means denying to a considerable number of patients the fruits of a well-established specialty of medical science. Delayed recovery of many orthopedic conditions and a needless resignation to the state of the hemiplegic are among the more obvious examples of this default.

Mr. Anderson is superintendent of the 117-bed Wyoming County Community Hospital, Warsaw, N.Y.

Moreover, it is certain that the inability of legitimate medicine to respond with positive measures to such familiar complaints as cervical or low back pain, sore muscles and arthritic symptoms has driven countless patients into the hands of chiropractors and other cultists.

A well-planned physiotherapy department can successfully meet this need and provide the hospital with a source of limited revenue and unlimited satisfaction.

MEDICAL STAFF ROLE

It must be recognized from the start that physical therapy is an extension of medical practice and not an isolated, self-sufficient technical service. Acceptance of this fact by the administration will help win necessary support of the medical staff, with whom all planning must begin. Directly, or through an interested physician, the administrator can request that a committee be formed to study the desirability of such a department. As the field is far from new, documentation of the methods and results of physical medicine are readily available. Details of organization are less standardized than clinical aspects, however, and many "organized" departments lack some element of structure or of medical direction.

A staff questionnaire may help assess attitudes and specific needs of the various physicians. The approach must be, in all sincerity, that the department is being considered only as a service to the physicians, and not as a form of competition with any modalities which may already have been provided for in conjunction with office practices.

Medical Supervision. Stating it baldly, the question is: does this department require more than a medical figurehead? Many established departments have settled for a physician or a staff committee only nominally in charge. This being the case, other hospital boards may be tempted to follow this course rather than to pay a salary or percentage for more active medical supervision. Such an attitude is mistaken, however.

Viewing physical medicine as, in fact, a special branch of medicine places the matter in proper perspective. Certainly the patient's greatest welfare requires that he remain under close medical direction throughout all phases of his treatment. But the average (even better-than-average) family physician is not competent to prescribe physical therapy intelligently or,

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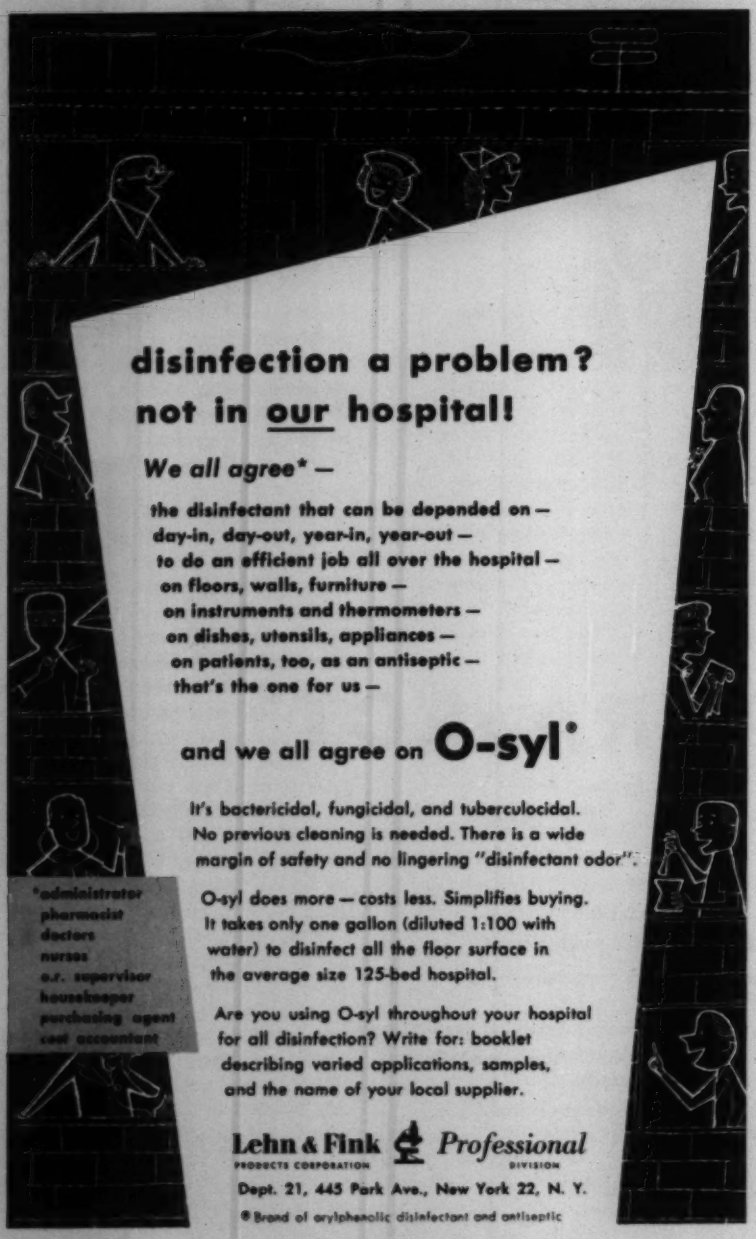
by the same token, to properly assess its results. The therapist, however skilled, does not possess a medical background, cannot legally prescribe and, therefore, does not provide medical supervision of patients. Clearly the hospital should not lead a nonphysician into the practice of medicine, and this will take place, to some degree, in the absence of a well-qualified physician-in-charge.

At this hospital, the full-time radiologist was appointed to this position. Selection of this specialist was ideal, as he would be available throughout the day and had the time to take an active part in patient care. Moreover, since the radiologist had no direct practice there needed be no apprehension on the part of our future referring physicians that in sending a patient to the physiotherapy department they would be turning him over to a competitor.

In order to qualify himself for this responsibility, our radiologist availed himself of a 120-hour course in physical medicine and rehabilitation offered by the postgraduate division of the University of Buffalo Medical School. While this opportunity was fortuitous, it is not unlikely that a physician anywhere could make informal arrangements at the nearest medical center to obtain such technical background with a similar expenditure of time.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FINANCIAL ARRANGEMENTS

The financial arrangement we made with the supervising physician gave him a small percentage of the gross receipts. Both sides considered this plan equitable, although this physician would have opposed, in principle, a salary basis. As the $3 fee per visit prevailing in this area was not increased but was made to include active professional attention, it was felt that the patient's interests also were fully satisfied. In this connection, differentiated fees corresponding to the number and types of modalities used during a visit probably will be adopted here as has been done extensively elsewhere.

A realistic look at the provision for paid medical direction supports the same conclusion. The physician strengthens the service both in fact and in the eyes of the patient, who naturally welcomes the doctor's interest in his case at no extra charge. The department has greater stature among other physicians and offers them more opportunity for consultation on a medical level. Such factors assuredly add up to a greater volume of work, more than compensating the hospital for the expense involved.

REFERRAL POLICY

The services of the department are available on prescription of the family physician or by referral to the physician-in-charge. The latter takes no patients of his own. For reasons already cited, most patients are referred; the physician-in-charge sees the patient as often as necessary and sends a report to the family doctor at the conclusion of treatments. This policy offers no threat to the status of the family physician; should he have physical therapy equipment of his own, he encounters absolute-

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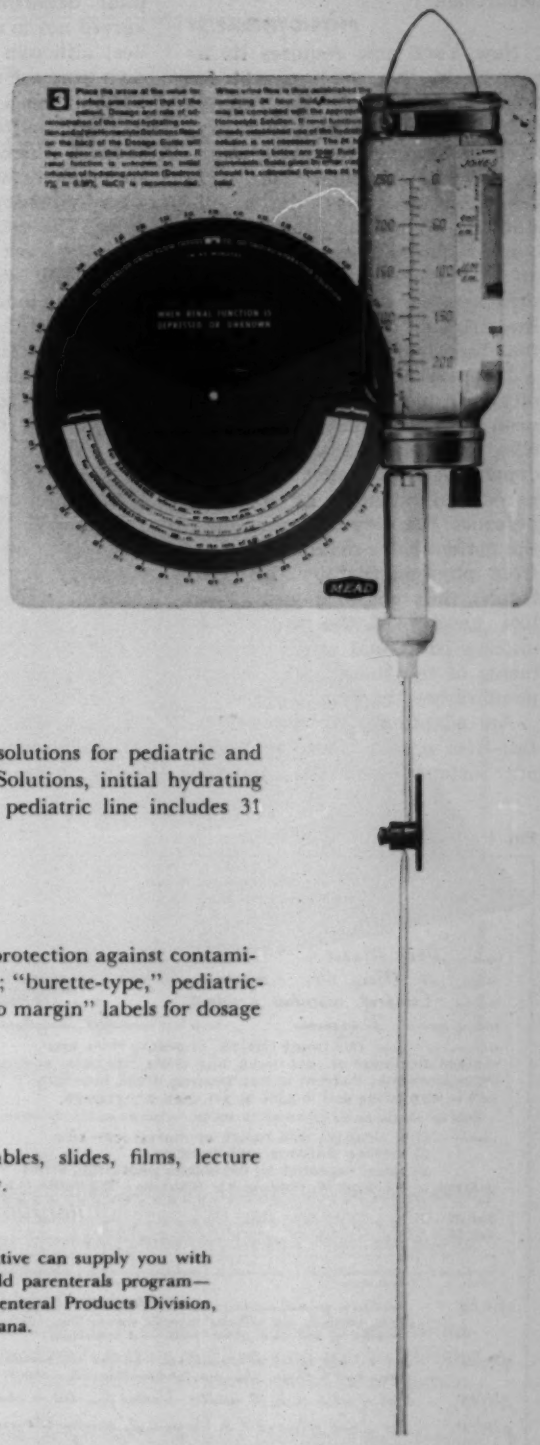

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ly no competition from the hospital department.

PHYSIOTHERAPIST

New York now requires its licensees in this field, except for those admitted under the "grandfather" clause, to have a degree from an approved four-year course in physical therapy. The wide range of modalities, the understanding of anatomy and physiology required, the importance of an adequate period of supervised practice—all these argue for no less stringent qualifications even in the absence of a legal requirement.

The presence of the supervising physician in no way eliminates the need for a well-qualified therapist, who remains the mainstay of the department. Only adequately prepared individuals with excellent personal qualities can insure that the patient gains maximum benefit from physical therapy. The good results thus obtained will stimulate growth of the department, making additional salary requirements of the therapist an investment rather than an expense.

An adaptation of the medical full-time principle was applied in our instance with the object of protecting and developing the hospital department. The therapist agreed not to conduct a private office, although home visits on his own time are not precluded. In return, he has a share in the prestige of the hospital and a guaranteed income which will reflect the future success which he, governed in part by general circumstances, attains. There is nothing to prevent our therapist from severing his connection with the hospital and practicing independently; however, it is doubtful that an ethical practitioner in this field could prosper in this small community without the activity and professional connections of the hospital department.

The sex of the physiotherapist was found immaterial even in a one-therapist department. Some provision should be made, however, for assistance from a female attendant now and then.

RECORDS, EQUIPMENT

The principal clinical records are shown in the accompanying illustrations. The basic "Physiotherapy Department" form (Fig. I below.) allows for identifying information, diagnosis and region involved, the physician's examination and orders, record of visits and progress notes made by the therapist for periodic review by the physician. The latter occasionally makes an entry in the progress notes to specify a change in treatment or to record a significant finding. At conclusion of the treatment a form letter (Fig. II, below), properly completed, is sent to the patient's physician by the physician-in-charge.

The basic equipment is rather standardized and can be purchased for about $2,000, plus the modest expense of improvising certain items in the hospital shop. The list of modalities used in this hospital during the first ten months of operation indicates the types of equipment we find to be in demand. (See Fig. III, p. 90).

The future range and frequency of modalities will depend not only on the types of patients referred but also on the propensities and ingenuity of the supervising physician and physiotherapist. Principal improvised equipment used to date includes parallel (walking) bars, shoulder ladder, shoulder

Fig. I

Wyoming County Community Hospital
PHYSIOTHERAPY DEPARTMENT

Date 1/26/55
Name Doe, Mabel C. Room 310
Address 16 Main St. Warsaw, N.Y. Age 71 Sex F
Diagnosis Cerebral vascular accident Onset 1/22/55
Referring Physician Burgeson Region To Be Treated Left Hemiplegia
Examination by Physician CVA Onset 1/22/55. Originally there was marked weakness of left limbs, but there has been moderate improvement. Patient is not entirely clear mentally but is improving and is able to sit, with assistance.

Treatment 1) M. Grading and range of motion left side
2) Sitting Balance and exercise.
3) When requested by attending physician, bring patient to P.T. dept for parallel bar training. Mo Martin M.D.

Mo.	Yr.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Jan	55																															
Feb	55																															

Date	Progress Notes
1/26/55	There is a general weakness in the left shoulder, elbow and left knee, which is the attached range of motion. Patient sat on edge of bed and stood with some assistance.
1/27/55	Sat on edge of bed with assistance. Walked with assistance from bed to chair. Has fair coordination. Sits in chair 10 minutes
2/4/55	Out of bed in chair 15 minutes. Walked from bed to chair.
2/8/55	Out of bed ½ hour - B.I.D. Progressively growing stronger.
2/11/55	Patient seen in physio. Hungry department. Started balance and gait training.
2/21/55	Walked from room to physiotherapy & returned. Pt. seems to fatigue less. Walks without assistance.
2/23/55	Climbs stairs using hand rail.
2/26/55	Shows much recuperation. Discharged from hospital.

Fig. II

Wyoming County Community Hospital
Warsaw, New York

DEPARTMENT OF PHYSICAL MEDICINE & REHABILITATION

2/26/55

Dear Doctor Burgeson,

Your patient, Mabel C. Doe,
received treatments in this department beginning on 1/26/55 and finishing on 2/25/55.

Following is a summary of the number and type of treatments he received during this period:

Type of Treatment	No. Applications
Sitting - balance exercises	27
Gait training	13

On discharge his condition is: cured ( ) -- markedly improved (X) -- slightly improved ( ) -- unchanged ( ) -- worse ( ) -- cured, but may recur ( ).

Thank you for sending this patient to us for treatment.
I remain

Yours very truly,

Mo Martin
Melvin S. Martin, M.D.

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a pioneer local anesthetic*

NOVOCAIN "most frequently used for subarachnoid block as well as for other forms of regional analgesia . . ."*

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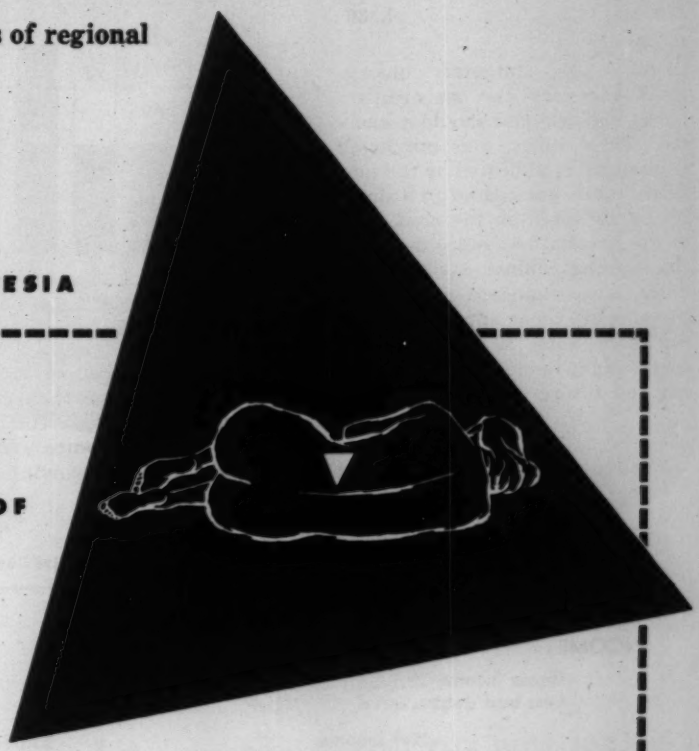

Safely and successfully employed in millions of cases . . .

*Bonica, J. J.: The Management of Pain. Philadelphia, Lea & Febiger, 1953, p. 475.

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For other regional analgesia:
Novocain solution 1 per cent and 2 per cent in ceramic imprinted ampuls and in vials of 30 cc. and 100 cc. (Other concentrations and forms with and without vasoconstrictors.)

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Modality	*Number*
Exercise, miscellaneous	1,448
Massage	876
Diathermy	575
Whirlpool (7 months only)	522
Infra-red	342
Gait training	323
Cervical traction	79
Crutch Walking	73
Low-volt stimulation	70
Ultra-violet	29
Miscellaneous	49
TOTAL	4,386

Fig. III

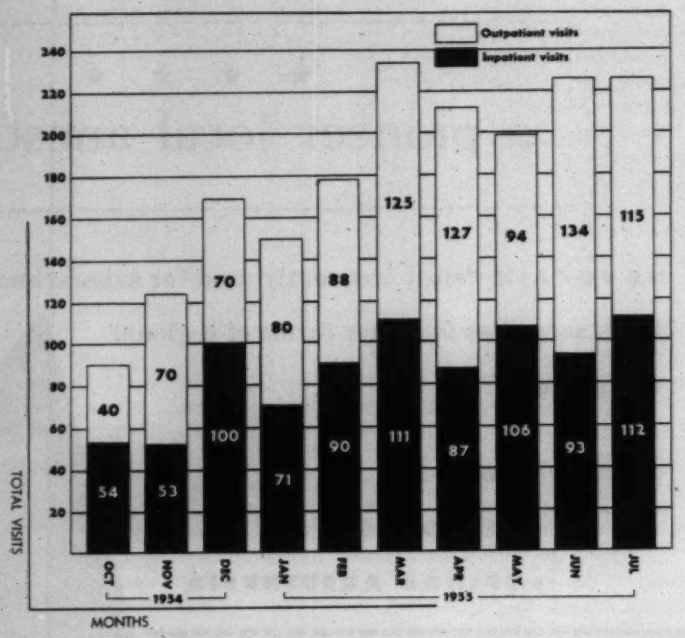
wheel, steps, stationary bicycle, wrist exerciser and an ordinary pulley for arm and shoulder exercise. These items, plus purchased equipment as indicated by the modality table, are housed in a single 28′ by 16′ room on the main floor of the hospital. An office desk and chair, filing cabinet, lavatory and toilet, large cupboard and cubicle curtains are other appointments of the room. Some 50 per cent more space might be desirable for present and future conveniences.

VOLUME, FINANCES

The table of modalities does not indicate the number of visits, as there have been to date an average 2.4 modalities per visit. Total visits for the first ten months are indicated by the accompanying graph (Fig. IV, above). This graph reflects the success of the department in the brief period involved. The list of referring physicians had increased from 6 the first month to 17 by the tenth month. Referrals were not particularly related to the volume of practice of the various physicians, emphasizing the well-known fact that some doctors are much more alert to the value of physiotherapy than others.

Allowing the department the first three months to "get off the ground," its financial record is reviewed in the adjoining columns for the following seven months, coincident with the new fiscal year starting Jan. 1, 1955.

Fig. IV



physiotherapy department income and expense

7 MONTHS ENDING JULY 31, 1955

INCOME		
Gross income	$3,793	
Less bad debt reserve	99	
Net income		$3,694
DIRECT EXPENSES		
Salary	$2,081	
Supplies	124	
Misc.	76	
Professional	1,544	
Total direct expenses		$2,825
Net gain on direct expenses		**$ 869**
		(per month: $124)
INDIRECT EXPENSES		
Retirement cont. on sal.	$ 187	
Linen service, est.	105	
Depreciation on equip.	134	
Utilities, cleaning, etc. @ 1.76 sq. ft. ann.	513	
Total indirect expenses		$ 939
Net loss on total expenses		**$ 70**
		(per month: $10)

SUMMARY

The benefits to be derived from a soundly organized rehabilitation service are such that the general hospital of whatever size or location is well-advised to consider developing such a facility if not otherwise available in the community. The experience of Wyoming County Community Hospital in the early months of operating its physical therapy department appears to justify our belief that, even in a rural area, the smaller hospital may bring this important medical specialty to its patients without fear of serious financial loss. ■

Photograph: DAVID LUBIN,
Medical Illustration Service,
U.S.V.A. Hospital,
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EASIER FOR YOUR NURSES TO OPERATE

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*Geoffrey Baker and Bruno Funaro in "Windows in Modern Architecture."

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maintenance of oxygen therapy equipment

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THE THERAPEUTIC VALUE of oxygen in patient care is recognized by all, but results are no better, of course, than the equipment administering the oxygen.

Today's iceless oxygen tent with automatic temperature control is a precision piece of machinery including refrigerating and air-circulating equipment. It can be compared in what it does to the air-conditioning plant of a large building. The oxygen tent is a package unit, cooling and supplying air, with or without fortification by oxygen, into a "room"—the tent canopy. Air supplied to the canopy is taken from the patient's room by means of a circulating fan located within the unit. Before it reaches the patient it is cooled by passing through a series of evaporator coils. Air taken from the patient's room also is used to condense the refrigerant, which has picked up heat from air being cooled for the patient's comfort.

The services of trained engineers are employed to keep large air-conditioning plants in efficient operating condition. The oxygen tent likewise needs careful care and maintenance.

THREE VULNERABLE PARTS

The three vulnerable parts of the oxygen tent that must have periodic cleaning, and must be accessible for cleaning, are:

(1) The evaporator or cooling coils.

(2) The condenser coil.

(3) The fan, or air-handling part.

Mr. Caddell is superintendent of buildings and grounds of the 236-bed William Beaumont Hospital, Royal Oak, Mich.

The *evaporator,* constructed of tubing surrounded by fins or thin metal strips, is the most important part. In some cases, however, it is given the least attention, since it is not easily accessible in most oxygen tents. The two common procedures for cleaning these coils are to blow them out with air or wash them by inserting a water hose into the chamber.

To maintain efficient operation, these coils should be removable. In certain tents, provision is made whereby the cooler can be opened and the coils and/or tubes cleaned. (This preventive maintenance operation should be done at least yearly, and preferably twice a year.)

The *condenser coil* cools or condenses the refrigerated gas by means of air from the room passing through or over the coil elements. This part can be compared to the radiator on a car. It is usually accessible for cleaning by backblowing or by brushing off the lint or dust. Keeping this "radiator" clean is very important, since accumulation of dust or lint retards the airflow and reduces efficiency of the refrigerating machinery.

The *fan or air-handling part* is designed to displace a certain volume of air per minute. Allowing the blades to build up dust will reduce their effective air-handling capacity.

The preventive maintenance program for oxygen tents, as with all mechanical equipment, starts with the purchase order. In selecting an oxygen tent, we give serious consideration to accessibility of the vulnerable parts; i.e., the cooling coils and air chamber must be readily accessible for cleaning and for visual inspection. We select tents with at least two panels of the cabinet removable, so that the refrigeration compresser, temperature and electric controls can be reached for adjustment. We make sure the unit's horsepower rating is sufficient capacity to prevent overloading.

With properly selected tents thus used throughout the hospital, we have found that scheduling preventive maintenance on oxygen tents after 200 running hours promotes efficient operation. This program assures doctor and nurse that the patient is getting enough clean, fresh air with the proper oxygen concentration.

MAINTENANCE SCHEDULE

The maintenance schedule may be set up by means of a record card. The hours of operation are recorded on this card; and when the maximum 200 hours has been reached, the tent is brought to the maintenance shop for service. Servicing, which is primarily cleaning, should not require more than 20 or 30 minutes, since the tent design allows access to the three vulnerable parts. Where the tent uses a throw-away type of filter, lint and dust are trapped and very easily removed.

If the evaporator or housing can be removed, inspect to make sure a good cleaning job has been done. If the evaporator and air chamber are enclosed and not accessible, cleaning, of course, must be by guesswork.

Electrical contacts should be in-

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spected and adjusted if necessary.

After the tent has been serviced and is ready for operation, we check the temperature control, a good practice. This is done by hanging a thermometer in the tent canopy and closing it at the bottom, setting the control to the desired tent temperature and running the unit until it cycles off. If the temperature setting and the thermometer reading agree, no adjustment is necessary. If not, the temperature control setting is adjusted to the thermometer reading. The control mechanism is frequently out of adjustment as a result of moving the tent through halls and corridors and over elevator landings.

The basic design of all oxygen tents is primarily the same. Some designs, however, are more accessible and lend themselves to ease of service and consequently longer life. This is an important consideration in developing a systematic program of oxygen tent maintenance which is sure to result in better patient care. ■

Notes and Comment

13 steps to safety

Obviously, a considerable amount of safety maintenance in the hospital requires just careful observation and good common sense. A good engineer is a safe engineer partly by instinct. But some "danger zones" and unsafe practices lie hidden away beneath the surface; these take some ferreting out on the engineer's part.

The check list accompanying an article in August 1955 *Better Maintenance* ("Good Housekeeping Fights Fires") is a good starting point.* How would you rate your hospital on the following safety check list?

- 1. Are all exits and fire escapes free from obstructions?
- 2. Are doors into the stair shaft at each floor level kept closed?
- 3. Are windows, except those required to be barred, free from heavy screens, bars or obstructions?
- 4. Are doors of the furnace room kept closed?
- 5. If soft coal is used, is the coal pile inspected biweekly for evidences of heating?
- 6. Are ashes placed in metal containers used for that purpose only?
- 7. If oil or gas fuel is used, is remote-control valve provided? —Is it operative?—Is it readily accessible?
- 8. Is all heating equipment including flues, pipes and steam lines—
  - (a) In good serviceable condition and well maintained?
  - (b) Properly insulated and separated from all combustible material by a safe distance?
- 9. In the kitchen, is there a hood above the range? Is it clean? —Is the hood vented to the outside?—Is vent pipe insulated or separated from combustible material by a safe distance?
- 10. Are doors to the room containing machinery for refrigerating system kept closed?—Are motors and cooling coils clean?—Is this room ventilated directly to the outside?—Is vent clear and unobstructed?—Are pressure relief valves and vents in good working order?
- 11. Are doors from laundry to main buildings kept closed?
- 12. Are thermostatic controls on dryers in good operating condition?
  - (a) Is tumbler free from accumulation of combustible lint and dust?—Is tumbler inspected and cleaned at frequent intervals?
  - (b) Is vent pipe from tumbler insulated or otherwise safely separated from combustible materials?
- 13. Are electric devices and irons equipped with automatic heat controls? ■

*An extensive check list also appears in the *Hospital Safety Manual*, joint publication of the American Hospital Association and the National Safety Council. Available on order to the Association, 18 E. Division St., Chicago 10. $2 per copy.

Alkali solution hazards

A number of serious accidents are being reported from unsafe practices of adding dry alkaline materials to water for making hot alkaline cleaning solutions. Some of these accidents have occurred from literally dumping a portion of a barrel of material into overheated water or adding excessive and undissolved quantities of the alkaline materials to room-temperature water without agitation of the solution.

It is well-known chemically that dry alkaline salts generate heat when they are dissolved in water. If large quantities of dry alkaline materials are added to heated water, enough local heat may be generated to vaporize considerable water to steam near the dissolving alkali.

An even more hazardous practice is to add large quantities of dry alkaline materials to the water at room temperature and then to cause this undissolved alkali at the bottom of the tank to be stirred, either purposely or accidentally, after the water has been heated. If the temperature of the water is sufficiently high, enough additional heat is locally generated in the vicinity of the caked and undissolved alkali so that the heated water forms steam very quickly. This rapidly formed steam may cause large quantities of the hot alkaline solution to be violently erupted from the tank, scalding persons attending the cleaning operation. In some cases, death has even been caused.

Accidents from this operation can easily be prevented if certain simple precautions are practiced. Add the necessary dry alkaline materials at room temperature before the water is heated. Add the alkali slowly and stir the solution to be sure that the dry material is dissolved as rapidly as it is added to the water.

If heated alkali tanks emit considerable steam, adequate outside exhaust ventilation should be provided in order to provide proper visibility for the operator of the cleaning operation and to prevent rusting of equipment and building structures.

The operator should be provided with adequate eye and facial protection and protective clothing to prevent splashing of the hot alkali solution on his skin or pervious clothing.—H. WILBUR SPEICHER, *writing in the* Safety News Letter, Automotive Machine Shop Section, *September 1955.*

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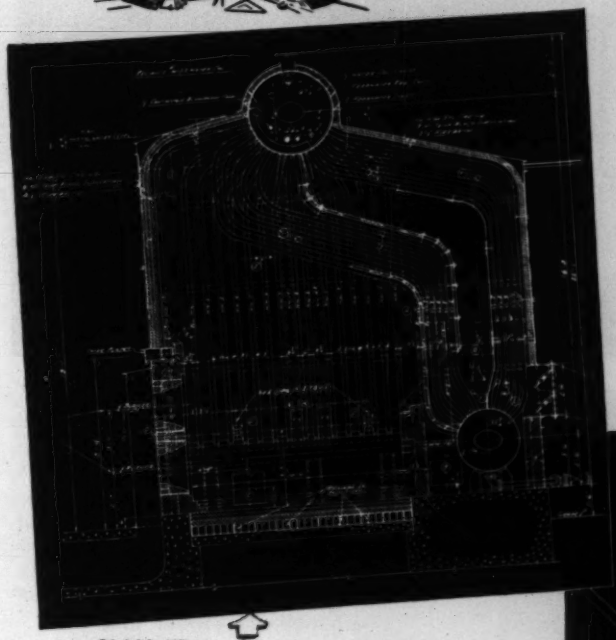

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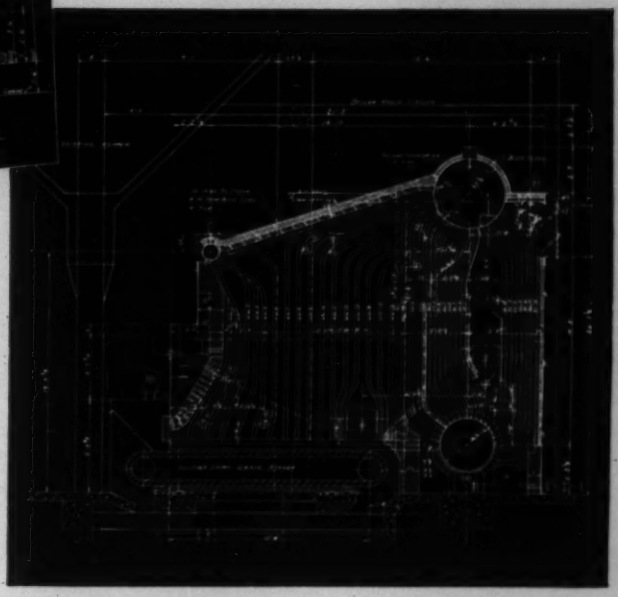
A 22,000 pounds steam per hour unit installed at Indiana Farm Bureau Refinery, Mt. Vernon, Ind.



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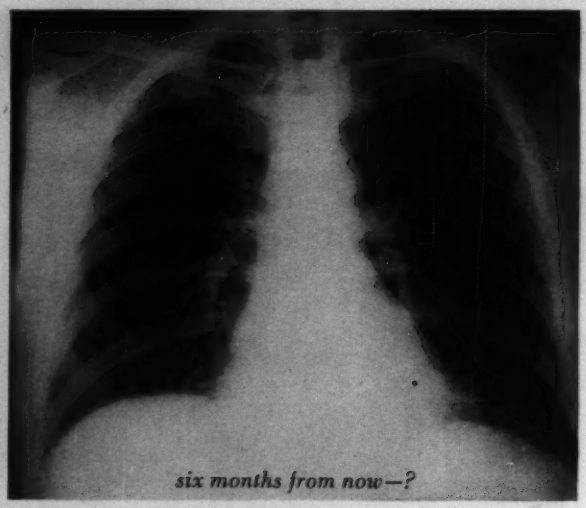

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MEN OVER 45!... Lung cancer, in men of your age, has increased so alarmingly in recent years that our doctors strongly recommend that you make a habit of having *two* chest x-rays every year: one, when you get your annual medical checkup; the other six months later.

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That's why we urge you and every man over forty-five to make semiannual chest x-rays a habit —for *life*.

To see our lifesaving film, "The Warning Shadow," call the American Cancer Society office nearest you or simply write to "Cancer" in care of your local Post Office.

American Cancer Society

we switched to centralized service

1. To assure better supervision.
2. To speed up food distribution.
3. To reduce labor costs.

JOHN L. HURLEY

WE CAN ALL AGREE food plays a very important role in the care, happiness and recovery of the patient in the hospital. Yet the service of hot and palatable meals to the patient three times each day with a minimum of time and labor cost presents a problem to every hospital, large and small.

For many months the administrative staff of St. Francis Hospital, Grand Island, Nebr., studied this problem with the thought of consolidating all dietary activities in one area. It was decided that centralized tray service and centralized dishwashing was one of the best answers to this problem, because:

1. It would provide better supervision and help eliminate the heavy turnover and absenteeism in the floor kitchens.

2. It would speed up food distribution.

3. It would assure more uniform portions of food.

Although the new system has not reduced, to any great extent, the number of employees required for the dietary department, it has concentrated these employees in one area, thus minimizing delays in service. I believe that this is the greatest advantage we have noted.

In one central tray service unit, we can provide better supervision and stimulate each dietary employee to have greater pride in his job. In the floor kitchen arrangement, we were not able to maintain this high degree of super-

CENTRAL dishwashing unit (above) features a double-compartment sink for pre-rinsing silver, a garbage disposal unit and a glass washer. The dishwashing machine is capable of handling more than 9,000 dishes per hour. Below, the trays proceed down the electrically-operated conveyor belt with the hot food being placed on the trays from the left and the cold foods from the right. The proximity of the refrigerators and hot food preparation unit to the cold and hot food portions of the serving counter assures minimum delay in transfer of foods.

Mr. Hurley is business manager of the 185-bed St. Francis Hospital, Grand Island, Neb. This hospital is operated by the Poor Sisters of St. Francis Seraphi.

REMODELED kitchen boasts 54 pieces of new, stainless steel equipment. Among the items included are the three-compartment pot and pan sink, toaster and slicer on the right and the mixer and pan storage rack on the left.

vision and inculcate as great a sense of responsibility in each of the floor kitchen personnel. As one would expect, we had a high turnover and absentee rate, thus causing us many interruptions in food service, especially in the early morning hours, on week-ends and on holidays.

Moreover, more than half of the dietary staff was hired on a part-time basis; in many instances, the employees were school girls, who did not depend on their job for a livelihood. Concentrating these people now in one central service area has placed greater emphasis on full-time dependable help.

TIME SAVINGS

Under the old system there was lapse of approximately one hour from the time the bulk food was placed in food trucks, delivered to the floors, portioned onto the trays and reached the patients. Now all patients are served in approximately 30 minutes.

Three to four hours were spent in each of the six floor serving kitchens to set up and deliver trays, wash the dishes, tidy the kitchen and reset trays for each meal. This same procedure is now accomplished in approximately four hours in one central kitchen and dishwashing unit—an over-all saving of from 15 to 20 man-hours daily.

Without sufficient supervision six different units had six different ways of getting a job done. Because of frequent changes in personnel for these units, oftentimes dishes were not properly washed and had to be redone before a meal could be served. Breakage and loss of dishes and silverware were also problems.

Now after food is prepared, it is transferred to an 18-foot serving counter in the main kitchen. The serving unit is the electrically-operated conveyor belt type with a hot and cold food section on either side. The food is then portioned onto pre-heated plates and placed on trays, which proceed down the conveyor belt to the bulk food conveyors (12 tray capacity) for transport to patient areas. An elevator is reserved for food service during meal periods.

During the noon meal eight employees staff the serving counter; only six employees are needed for morning and evening. We have achieved more uniform servings and closer supervision under this system.

CENTRAL DISHWASHING

Soiled dishes and trays are picked up by floor nursing aides and taken to a central dishwashing room, adjacent to the main kitchen, where a conveyor-type machine pre-rinses, washes and sterilizes all dishes and silver. There is a separate washer-dryer for glassware.

Other features of the dishwashing room are a garbage-disposal unit and automatic dishwashing-compound dispenser. Walls of the dishroom and outer corridor are finished in colorful plastic tile for ease in cleaning.

After dishes have been washed and steam-dried, they are returned to lowerators in the central serving counter. Paper tray covers and the silver, wrapped in napkins, are placed on a shelf above the tray-lowerator to avoid delay when trays are started down the line.

A small work unit has been set aside in the kitchen for the preparation of modified diets and the instruction of student nurses.

KITCHEN TO PATIENT

The success of centralized food service is dependent almost entirely upon the speed with which trays are delivered from the kitchen to the patient. At St. Francis Hospital there is a lapse of eight to ten minutes from the time each tray truck leaves the main kitchen until the last of the 12 trays is delivered to the patient.

Two dietary aides transport the tray trucks to each floor where they are then taken over by nursing personnel. If it is necessary, the floor aide will return immediately to the kitchen for another truck, depending upon the number of patients in her particular division.

Most of the patients are highly complimentary of the new system and have stated in the patient opinion questionnaire that the food was "appetizing, hot and attractively served."

KITCHEN ALTERATIONS

Few changes in layout were required to install the new type of tray service. Several wall partitions were changed and an office for the dietitian was added. A new lighting system and ceilng fans were installed.

There are 54 pieces of new, stainless steel equipment, including four, walk-in refrigerators with reach-in doors for the meat and dairy units. A walk-in, zero degree refrigerator allows quantity buying and storage of many frozen foods. There is a completely-equipped bakery unit.

Conveniently-placed lavatory facilities throughout the installation encourage the practice of high standards of personal cleanliness among dietary employees. Other sanitation features of the remodeled kitchen include lever-controlled sink drains, rounded corners for all counter tops and drawers, and a steam injector for the pan-washing sink. Several

floor drains, a hose connection and electrical outlets were conveniently placed in working areas.

During the eight-month renovation period a temporary kitchen was set up in an adjoining dining room, which now houses the dishwashing equipment.

The advent of centralized service has assured us of closer supervision of personnel—a potential cost control factor. We have found that the new system saves space (six floor kitchens are now available for chart, linen and storage rooms), saves time by streamlining food distribution and cuts payroll costs $3,000 annually. ■

ADA CONVENTION IN REVIEW—

do-it-yourself dietitians are *passé*

ST. LOUIS—The dietitian's four-sided role in today's hospital—diet therapist, equipment and design consultant, management expert and researcher—is not chosen. It is the challenge that medical and industrial science has created and which must be accepted by the professionally qualified dietitian and her auxiliary nonprofessional workers if the best possible dietary care is to be rendered economically and efficiently.

Each of the 3,500 dietitians attending the recent American Dietetic Association convention learned that with high labor and food costs, advances in medical research which have direct implications in diet therapy, and the rate at which industry develops better management tools, she just can't keep pace and do the job alone. The professionally qualified dietitian must train auxiliary nonprofessional food service personnel to assume some of her rou-

MARGARET GILLAM, 1955 recipient of the Marjorie Hulsizer Copher award for distinguished service to the dietetics profession, views award packet with Frank R. Bradley, M.D., director of Barnes Hospitals, St. Louis. Miss Gillam, the first AHA dietetics specialist, originated the Master Menu for hospitals, the only monthly menu service that makes provision for modified diets. She is the first recorded dietitian to develop a pay cafeteria.

ALASKA TO AFRICA, several foreign countries as well as nearly every state in the Union sent representatives to the 38th annual ADA meeting. Doris Vicker (left), chief dietitian at the USPHS Alaska Native Hospital, Anchorage, and Renate Stern, Johannesburg, South Africa dietitian doing postgraduate work at the Ohio State University Hospitals, Columbus, examine Master Menu wall card and transfer slip at the American Hospital Association booth in the auditorium.

GUESTS at the ADA Tea and Open House held at Wohl Hospital (Barnes group) included: (seated, left to right) Kate Daley, food manager, Scruggs, Vandervoort, Barney, St. Louis; Fern Gleiser, immediate past president of the American Dietetic Association and professor of institution management and economics, University of Chicago; and Margaret Ohlson, Ph.D., head of Department of Foods and Nutrition, Michigan State College, East Lansing. Standing left to right are Helen MacLachlan, associate professor of dietetics, St. Louis University Hospitals, and Hostess Henrietta Becker, director of the dietary department, Barnes Hospital.

tine duties so that she can devote more of her time to tasks that demand her professional background.

DIET THERAPY

She must keep abreast of and implement the vast amount of research being conducted in all areas of diet therapy. Some of the diet therapy research reports given at the meeting were:

Cholesterol level. Frederick J. Stare, M.D., chairman of Harvard University's nutrition department, reported that the serum cholesterol level, considered an important factor in atherosclerosis, will not be increased if a high calorie, high fat diet is served, providing weight gain is prevented by vigorous exercise. Sudden weight gain in man, even on a low fat, low cholesterol diet, results in elevation of serum lipids.

Niacin deficiency. Grace A. Goldsmith, M.D., head of Tulane University's Division of Nutrition and Metabolism, explained their recent niacin deficiency studies support the theory that pellagra is due to the lack of niacin or tryptophan and not to the deficiency of several of the B-complex vitamins. Moreover, pellagra was induced more readily with diets containing corn than with those containing wheat. The close association of corn diet with pellagra may be due, in part, to the low niacin and tryptophan content of corn, she explained. However, other factors, such as amino acid inbalance in corn diets or the presence of some inhibitory substance in corn, have not been eliminated as contributory causes of the pellagragenic effect of this cereal.

Therapeutic hypnosis. Case studies of 12 patients at Parkland Memorial Hospital, Dallas, subjected to therapeutic hypnosis to correct their nutritional deficits, tend to indicate that:

1. A compulsion to eat induced by post-hypnotic suggestion can be successfully accomplished in patients suffering from burns and other forms of illness.

2. The creation of a desire for a patient to correct nutritional deficits through hypnosis appears superior to other methods of therapy.

Iron absorption. Three Washington University researchers reported that the amount of iron absorbed from foods by normal subjects is 10 per cent or less. Their further studies have indicated that abscorbic acid usually increased the assimilation of food iron even more in iron-deficient than in normal subjects.

If eggs were baked into cake or corn bread, or scrambled and served with toast, bacon, cereal and fruit juice, greater assimilation could be detected only with relatively large amounts (200 to 250 cc.) of citrus fruit juices.

Calcium retention. The retention of calcium by ten, pregnant, unmarried women from 14 to 30 years of age and with an intelligence range below average to college level was reported by Genevieve Stearns, Ph.D. The Iowa State University research professor noted that calcium retention appeared to vary inversely to the amount of emotional disturbance. The emotionally-disturbed subject might lose 300-400 mg. calcium daily, the stable serene subject retain that much or more. If the adolescent is emotionally stable, a dietary regimen considered adequate for other pregnant women will permit ample retention in the adolescent.

Protein supply. Conrad A. Elvehjem, Ph.D., professor of biochemistry at the University of Wisconsin, in reviewing the newer findings on amino acids, reflected that nutritionists are not ready to shift their emphasis from a consideration of proteins in nutrition to amino acids. He said this was true even though there are extensive figures for the amino acid content of a large variety of human foods and preliminary estimates of the requirement of several amino acids for certain age groups have been established.

He said there is no need for excess protein in the diet as long as there is an adequate supply of each individual amino acid and the amino acids in these foods are present in available form. If incomplete proteins are used, excess protein may be more deleterious than beneficial. In order to overcome the inadequacies of incom-

New Officers

The 1955-56 officers of the American Dietetic Association are: president, Winifred Howard Erickson, director, department of dietetics, Ancker Hospital, St. Paul; president-elect, Lucille M. Refshauge, director, department of dietetics, Hartford (Conn.) Hospital; secretary (retained), Mary Ellen Johnson, education director of dietetic interns, Colorado State Hospital, Pueblo; treasurer, Doris Johnson, Ph.D., director of dietetics, Grace-New Haven (Conn.) Community Hospital; and speaker of the house of delegates, Marguerite L. Pettee, nutritionist, University of Colorado Medical School, Denver.

plete proteins, Mr. Elvehjem recommended that a combination of several proteins from different sources be used.

NEW PRODUCTS

Several dairy products have been introduced to aid the homemaker and the dietitian in preparing more acceptable modified diets. H. E. O. Heineman, director of the research division of the Pet Milk Company, St. Louis, noted the following new items:

1. Modified fluid milks with the butterfat content reduced to varying degrees.
2. High calorie milk consisting of whole milk with increased nonfat milk solids.
3. Canned whole milk with an improved flavor.
4. Low sodium fluid milk.
5. Low fat frozen desserts.

NEW EQUIPMENT

If the dietitian is to produce a menu within the budget, particularly in this day of high wages, she needs to employ every tool at her command to reduce costs. In many cases, the effective tool could be a piece of equipment. Some of the new items in the food equipment showcase reported by Leslie W. Scott, director of the Division of Hotel, Restaurant and General Institutional Management at Michigan State University, are:

1. Tea urn which automatically brews a liquid concentrate of tea with a measured amount of hot water at the spigot.
2. Oven that combines air pressure inside the unit with very high heat for quick cookery of many foods.
3. Deep-fat fryer which operates under pressure and reduces cooking time in some cases by more than 75 per cent.
4. Continuous hamburg unit, which is automatically controlled from the time the meat is inserted in the grinder until the hamburger is popped into the bun.
5. An automatic, bag-to-plate, french fryer unit which enables one employee to process a ton of potatoes.

MANAGEMENT TOOLS

Time studies and analysis of food waste were two of the management tools reported that can help the dietitian in her job.

Beatrice Donaldson, Ph.D., associate professor and head of Institution Management Laboratory at the University of Wisconsin, and Harry H. Pope, president of Pope's Cafeterias, St. Louis, agreed that time studies in the hospital dietary department can uncover "hidden costs" in menu preparation and service.

Mr. Pope pointed out that time studies usually show that most kitchens do not need more labor saving; what is needed is more utilization of the labor which is available. He said the big loss in food preparation labor is "observation time" and "waiting time." The time spent watching chicken frying in the deep fat fryer, for example, is not productive. Work should be scheduled so that the cook's hands are busy while his eyes are used for observation.

The study of all refuse and edible foods discarded during the preparation and service of meals can uncover faulty preparation techniques, poor purchasing stand-

ARCHITECTS: COOLIDGE, SHEPLEY, BULLFINCH AND ABBOTT

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EQUIPMENT FOR THE PREPARATION AND SERVING OF FOOD

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ards and patients' food dislikes. Dietary Consultants Constance L. Brine, Ph.D. and Edith B. Tate, in analyzing the waste in three large institutions (two geriatric and one children's), reported that food losses in terms of pounds were approximately one-fifth to one-fourth of the total food issued. The greatest losses in proportion to issues occurred in the leafy, green and yellow vegetables; potatoes and sweet potatoes; meat, poultry and fish; and dry beans, peas and nuts. When the average nutritive values of the food issues were compared with the National Research Council's Recommended Dietary Allowances (weighted according to population makeup of each institution), the institutions studied were found to have adequate food supplies. When the food losses were deducted, however, the food eaten in the two geriatric institutions was low or border-line with respect to several nutrients—iron in both institutions, Vitamin A and niacin in one, and ascorbic acid in another.

RESEARCH ESSENTIAL

In large quantity food service certain problems arise because most foods are exposed to the effects of holding, before and after cooking. Karla Longrée, Ph.D., professor of institution management, New York State College of Home Economics, Cornell University, reminded the group that this holding may affect changes in the foods' nutritive value, color, texture, flavor and palatability.

In order to minimize these changes and seek out the reasons for these breakdowns, quantity food research is necessary. However, Miss Longrée pointed out that "it takes a certain flexibility of mind to chuck a day that was meant to be a 'controlled test' and still see that some benefit was derived from it." First of all, there is a problem of expense for many foods have to be discarded after experimentation.

A second difficulty that Miss Longrée noted in undertaking food research projects is fitting the project into a busy production schedule when the regular kitchen equipment may have to be used during some phase of the experimental study.

Thirdly, she said, the control of variables may be exceedingly difficult to achieve when the experimental hours overlap the regular food production period.

It takes much understanding and patience on the part of all involved, Miss Longrée warned, to survive these trials. The over-all objective of all dietary service—the best possible patient care——must loom to the foreground, sparked by the professionally qualified dietitian's enthusiasm carried down to all of her auxiliary workers. ■

Master Menus for January

THE JANUARY 1956 Master Menu is planned to provide good food for every hospital patient.

The general diet is planned to reduce to a minimum the modification necessary to meet all therapeutic food needs of patients, and consideration is given to minimizing expenses through menu control of raw food and labor costs.

The general diet forms the basis of the seven most frequently used modified hospital diets. Selections to be served on the general diet are set in boldface type.

Modified diets in the menu plan are the soft, full liquid, high protein, high calorie, low calorie, low fat and measured or weighed.

The American Hospital Association recommends the use of the Master Menu as a complete set of nutritionally-adequate menus at a medium cost level or as a suggestion list for menu items.

Master Menu kits containing the wall cards, sample transfer slips and *Master Menu Diet Manual* are available to users of the menus. The kits are priced at $2 and may be secured by writing the Editorial Department of HOSPITALS. Single copies of the manual may be purchased for $1.50.

Full directions for using the Master Menu are in the manual as well as information on preparing 15 other modified diets with the aid of the menus.

Summary of Dinner Meats

Item	*Dates on Menu*	*Total*
Beef	January 4-7-10-15-19-23-28	7
Veal	January 2-12-18-24-30	5
Lamb	January 9-17-21-26	4
Pork	January 11-16-29	3
Poultry	January 1-3-8-22-25	5
Fish	January 6-13-20-27	4
Variety Meats	January 5-14-31	3
		31

January 1

1. **Orange halves**
2. Orange juice
3. **Crisp rice cereal or oatmeal**
4. **Soft cooked egg**
5. Bacon
6. **Danish coffee ring**

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7. **Tomato juice**
8. **Whole wheat wafers**
9. **Roast goose, giblet gravy**
10. Roast chicken
11. **Brown rice**
12. Parsley potatoes
13. **Cauliflower polonaise**
14. Mashed squash
15. **Grapefruit and orange salad**
16. **French dressing**
17. **Eggnog pie**
18. Vanilla ice cream
19. Lime ice
20. Pink grapefruit sections
21. Grapefruit juice

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22. **Cream of mushroom soup**
23. **Croutons**
24. **Shrimp-avocado salad—sliced tomatoes**
25. Minced lamb—asparagus
26. Cold sliced lamb—asparagus
27. Baked sweet potatoes
28. **Baked potato on half shell**
29. **Celery and carrot sticks**
30. ———
31. **Baked apple with honey whipped cream**
32. Applesauce
33. Floating island
34. Fresh pineapple
35. Blended citrus juice
36. **Parker House roll**

‡ Arabic numerals indicate page on which recipe may be found in "Large Quantity Recipes," by Margaret E. Terrell. Philadelphia, J. B. Lippincott, $7.

January 2

1. **Half grapefruit**
2. Grapefruit juice
3. **Rolled wheat or puffed rice**
4. **Poached egg**
5. Bacon
6. **Toast**

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7. **Consomme**
8. **Saltines**
9. **Baked breaded veal cutlet**
10. Broiled veal steak
11. **Baked noodles**
12. Cubed potatoes
13. **Harvard beets**
14. Sliced beets
15. **Lettuce wedges**
16. **Roquefort dressing**
17. **Cranberry crunch a la mode**
18. Butterscotch pudding with whipped cream
19. Lemon gelatin cubes
20. Sliced banana in orange juice
21. Orange juice

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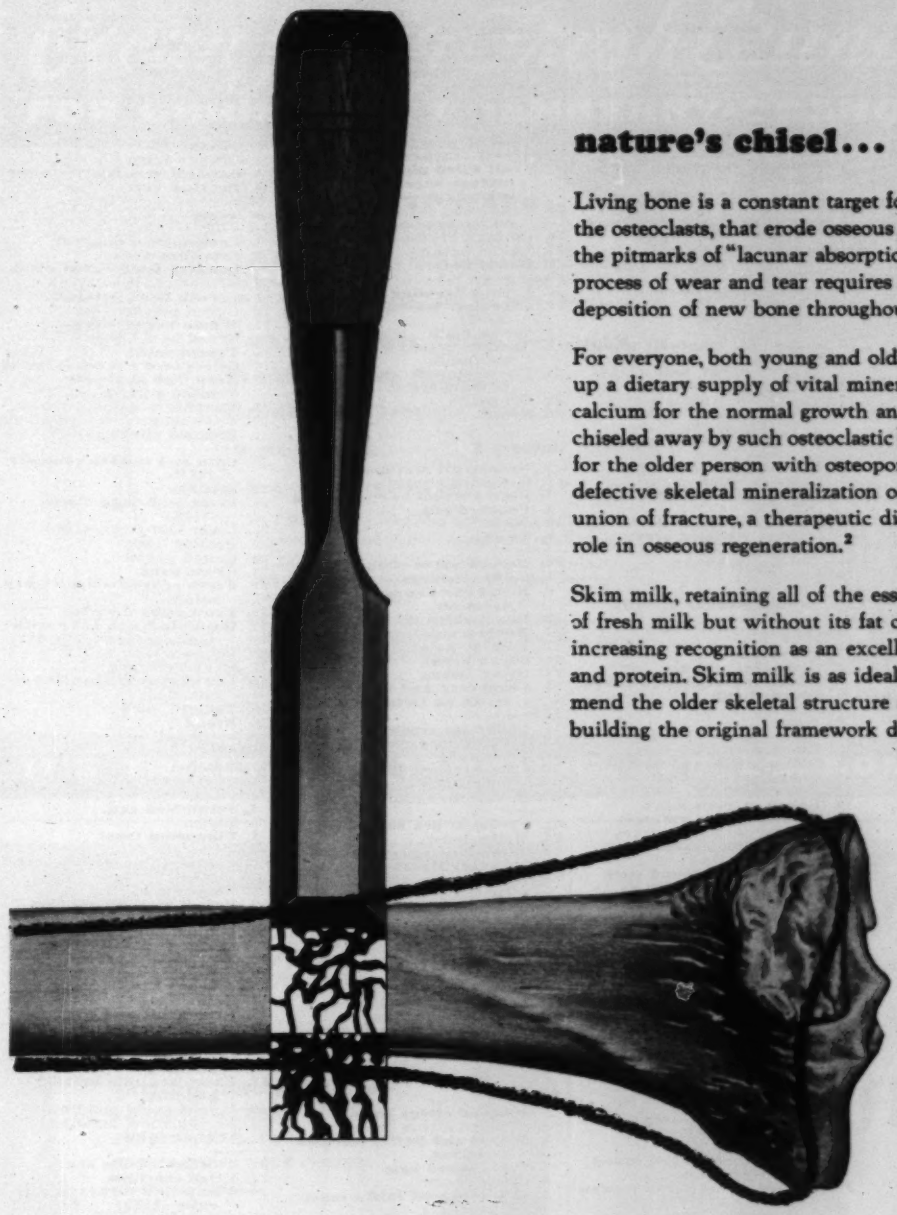
22. **Chicken soup with rice**
23. **Crisp crackers**
24. **Scalloped potato—cold cuts**



nature's chisel...

Living bone is a constant target for the chemical chisels, the osteoclasts, that erode osseous tissues and leave the pitmarks of "lacunar absorption."[1] This continuous process of wear and tear requires the formation and deposition of new bone throughout every individual's life.

For everyone, both young and old, it is necessary to keep up a dietary supply of vital minerals, particularly calcium for the normal growth and replacement of bone chiseled away by such osteoclastic erosion. But especially for the older person with osteoporosis, for those with defective skeletal mineralization or with delayed union of fracture, a therapeutic diet plays an important role in osseous regeneration.[2]

Skim milk, retaining all of the essential mineral nutrients of fresh milk but without its fat content, is gaining increasing recognition as an excellent source of calcium and protein. Skim milk is as ideal in helping to mend the older skeletal structure as it is in building the original framework during younger years.

Like other Borden food products, Borden's Starlac Non-Fat Dry Milk and Borden's Non-Fat Fluid Skimmed Milk are of the highest quality and are processed under the most hygienic conditions. The fluid Skimmed Milk, for example, like all Borden milk products, is made from the finest of fresh milk, pasteurized and processed under the most modern, hygienic conditions for improved palatability and greater nutritive value.

With Starlac, Borden pioneered in making wholesome non-fat dry milk available to Americans everywhere. Both types of Borden's Non-Fat milk are economical, eminently suitable for use in the home and in the hospital.

Manufacturers and distributors of BORDEN'S Instant Coffee STARLAC non-fat dry milk • BORDEN'S Evaporated Milk • Fresh Milk • Ice Cream • Cheese • BREMIL powdered infant food • MULL-SOY hypoallergenic food • BIOLAC infant food • DRYCO infant food • KLIM powdered whole milk

The *Borden* Company
350 Madison Avenue, New York 17, N. Y.

[1] Swenson, P. C., and Jeffery, R. B. : G. P. 7:34 [Feb.] 1953.
[2] Stieglitz, E. J. : Geriatric Medicine, ed. 2, Philadelphia, W. B. Saunders Company, 1949, p. 697.

25. Welsh rarebit on melba toast—chopped spinach (‡103)
26. Broiled steak—chopped spinach
27. Stuffed baked potato
28. ———
29. **Green and red cabbage salad**
30. **Sour cream dressing**
31. **Fruited gelatin, whipped cream**
32. Canned fruit gelatin
33. Chocolate rennet-custard
34. Unsweetened canned loganberries
35. Pineapple juice
36. **Pumpernickel bread**

January 3

1. **Tomato juice**
2. Tomato juice
3. **Wheat flakes or farina**
4. **Scrambled egg**
5. Bacon
6. **Raisin toast**

7. **Noodle soup**
8. **Crisp crackers**
9. **Chicken fricassee—cranberry orange relish**
10. Roast chicken
11. **Brown rice**
12. Brown rice
13. **Whole carrots**
14. Whole carrots
15. **Celery—olives**
16. ———
17. **Lemon fluff pudding with custard sauce**
18. Lemon fluff pudding with custard sauce
19. Lemon fluff pudding
20. Unsweetened canned bing cherries
21. Grapefruit juice

22. **Creamy potato soup**
23. **Saltines**
24. **Swedish meat balls (‡126)**
25. Broiled beef patties
26. Broiled beef patties
27. Riced potatoes
28. **French style green beans**
29. **Tossed salad**
30. **Celery seed dressing**
31. **Honey pecan tart**
32. Canned peaches
33. Raspberry gelatin
34. Unsweetened canned peaches
25. Limeade
36. **Corn muffins**

January 4

1. **Banana**
2. Blended citrus juice
3. **Brown granular wheat cereal or corn flakes**
4. **Soft cooked egg**
5. Grilled Canadian bacon
6. **Toast**

7. **Clam chowder**
8. **Oyster crackers**
9. **Swiss steak**
10. Broiled cubed steak
11. **Mashed potatoes**
12. Parsley potatoes
13. **Pimiento diced celery**
14. Green peas
15. **Sliced lettuce salad**
16. **Russian dressing**
17. **Apple crisp ‡(347)**
18. Apple crisp
19. Pineapple whip
20. Fresh apple
21. Orange juice

22. **Cream of tomato soup**
23. **Croutons**
24. **Grilled Canadian bacon—candied sweetpotatoes**
25. Scrambled egg with bacon curls
26. Broiled veal steak
27. Baked potato
28. **Spinach with lemon**
29. **Grapefruit and cress salad**
30. **Paprika French dressing**
31. **Chocolate angel food with white mountain icing (‡276)**
32. Chocolate angel food, white mountain icing
33. Baked custard
34. Unsweetened canned plums
35. Mixed fruit juice
36. **Bread**

January 5

1. **Orange juice**
2. Orange juice
3. **Wheat and barley kernels or hominy**
4. **Scrambled egg**
5. Bacon
6. **Whole wheat muffins**

7. **Consomme**
8. **Crisp crackers**
9. **Pan-fried liver**
10. Broiled liver
11. **Whipped potatoes**
12. Whipped potatoes
13. **Whole kernel corn**
14. Sliced beets
15. **Peach, date and nut salad**
16. **Chantilly dressing**
17. **Cranberry ice**
18. Cranberry ice
19. Cranberry ice
20. Unsweetened canned apricots
21. Grapefruit juice

22. **Cream of vegetable soup**
23. **Saltines**
24. **Spanish meat loaf (‡128)**
25. Broiled beef patties
26. Broiled beef patties
27. Baked noodles with tomato puree
28. **Pattypan squash with lemon juice**
29. **Lettuce, spinach and radish salad**
30. **Savory French dressing (‡242)**
31. **Pineapple upside down cake, whipped cream**
32. Canned pears
33. Vanilla ice cream
34. Fresh pear
35. Fruitade
36. **Baking powder biscuits**

January 6

1. **Tangerine**
2. Grapefruit juice
3. **Rolled wheat or corn flakes**
4. **Poached egg**
5. Bacon
6. **Toast**

7. **Essence of celery soup**
8. **Whole wheat crackers**
9. **Baked salmon loaf—egg sauce (‡170)**
10. Baked salmon steak
11. **Parsley whole potatoes**
12. Parsley whole potatoes
13. **Green Lima beans**
14. Diced carrots
15. **Stuffed prune salad with pecan garnish**
16. **Cream mayonnaise**
17. **Chocolate peppermint sundae**
18. Vanilla ice cream
19. Whipped jello
20. Unsweetened canned bing cherries
21. Orange juice

22. **Oyster stew (‡45)**
23. **Oyster crackers**
24. **Toasted cheese sandwich—watermelon pickle—potato chips**
25. Baked cheese sandwich—asparagus
26. Cottage cheese—asparagus
27. Baked potato
28. ———
29. **Tomato and parsley salad**
30. **French dressing**
31. **Canned peaches—Hawaiian jumbles (‡294)**
32. Canned peaches
33. Vanilla pudding with apricot nectar sauce
34. Fresh apple
35. Apple juice
36. ———

January 7

1. **Banana**
2. Prune juice with lemon
3. **Rolled wheat or crisp corn cereal**
4. **Scrambled egg**
5. Crisp bacon
6. **Honey buns**

7. **Grapefruit juice**
8. ———
9. **Sauerbraten (‡122)**
10. Roast beef
11. **Potatoes au gratin**
12. Riced potatoes
13. **Green peas**
14. Green peas
15. **Shredded carrot and raisin salad**
16. ———
17. **Cream puff**
18. Vanilla pudding with chocolate sauce
19. Lemon rennet pudding
20. Unsweetened canned peaches
21. Consomme

22. **Clam chowder**
23. **Oyster crackers**
24. **Fruit salad plate with cottage cheese—asparagus**
25. Peach and cottage cheese on lettuce—asparagus
26. Cottage cheese—asparagus
27. Baked potato
28. **Baked potato**
29. ———
30. **French dressing**
31. **Chocolate walnut cookies (‡292)**
32. Prune whip
33. Tapioca cream with meringue
34. Unsweetened canned boysenberries
35. Grapeade
36. **Bread**

January 8

1. **Grapefruit sections**
2. Grapefruit juice
3. **Rolled wheat or corn flakes**
4. **Poached egg**
5. Bacon
6. **Toast**

7. **French onion soup (‡32)**
8. **Crisp crackers**
9. **Roast chicken with giblet dressing**
10. Roast chicken
11. **Mashed potatoes**
12. Parsley potatoes
13. **Green beans**
14. Green beans
15. **Cranberry and orange relish on lettuce (‡190)**
16. ———
17. **Coffee ice cream**
18. Vanilla ice cream
19. Lemon ice
20. Unsweetened canned dark cherries
21. Mixed citrus juice

22. **Cream of pea soup**
23. **Melba toast**
24. **Scrambled eggs—grilled turkey livers—squash**
25. Scrambled eggs—grilled turkey livers—squash
26. Grilled turkey livers—squash
27. Baked potato
28. ———
29. **Celery curls**
30. ———
31. **Chocolate cream pie (‡317)**
32. Orange and banana cup
33. Chocolate pudding
34. Orange and banana cup
35. Apple juice
36. ———

January 9

1. **Blended citrus juice**
2. Blended citrus juice
3. **Wheat and barley kernels or farina**
4. **Soft cooked egg**
5. Grilled ham
6. **Whole wheat raisin toast**

7. **Vegetable soup (‡34)**
8. **Saltines**
9. **Stuffed lamb shoulder—mint jelly**
10. Roast lamb
11. **Riced potatoes**
12. Rice potatoes
13. **Glazed carrots**
14. Sliced carrots
15. **Shredded cabbage and green pepper salad**
16. **Olive French dressing**
17. **Orange fruit cake (‡274)—orange frosting (‡282)**
18. Orange layer cake
19. Pineapple whip
20. Grapefruit sections
21. Grapefruit juice

22. **Cream of turkey soup**
23. **Crisp crackers**
24. **Spaghetti with meat sauce**
25. Casserole of spaghetti with tomato puree
26. Baked veal chop
27. Spaghetti with tomato (omit on Soft Diet)
28. **Fresh spinach**
29. **Cottage cheese on lettuce**
30. ———
31. **Stewed apricot compote**
32. Canned peeled apricots
33. Lime gelatin
34. Unsweetened canned apricots
35. Fruitade
36. **Hard rolls**

January 10

1. **Orange halves**
2. Orange juice
3. **Oatmeal or crisp rice cereal**
4. **Poached egg**
5. Bacon
6. **Toast**

7. **Consomme a la royal**
8. **Crisp crackers**
9. **Country fried cubed steak**
10. Grilled chopped steak
11. **French fried potatoes**
12. Cubed potatoes
13. **Whole kernel corn**
14. Sliced new beets
15. **Tossed salad**
16. **Celery seed French dressing**
17. **Deep dish apple pie**
18. Fruited gelatin
19. Raspberry gelatin cubes
20. Unsweetened canned plums
21. Blended citrus juice

22. **Corn and tomato chowder (‡42)**
23. **Saltines**
24. **Liver loaf—egg sauce (‡135)**
25. Liver loaf—egg sauce
26. Broiled liver
27. Baked potato
28. **Green peas**
29. **Fresh pear and strawberry salad**
30. **Fruit salad dressing (‡239)**
31. **Date sandwich cake with lemon sauce (‡264, 384)**
32. Prune whip
33. Baked custard
34. Unsweetened Royal Anne cherries
35. Tomato juice
36. **Bread**

January 11

1. **Banana**
2. Grapefruit juice
3. **Puffed rice or rolled wheat**
4. **Scrambled egg**
5. Bacon
6. **Cinnamon toast**

7. **Cream of mushroom soup (‡44)**
8. **Toast sticks**
9. **Baked glazed Canadian bacon or broiled flounder**
10. Broiled flounder fillets
11. **Whipped potatoes**
12. Whipped potatoes
13. **Kale with lemon or green beans**
14. Green beans
15. **Grapefruit and red apple section salad (‡214)**
16. **French dressing**
17. **Chocolate chip bread pudding**
18. Chocolate chip bread pudding
19. Lemon snow pudding
20. Lemon snow pudding
21. Orange juice

22. **Chicken noodle soup**
23. **Crisp crackers**
24. **Plantation turkey shortcake (‡162)**
25. Creamed turkey—asparagus
26. Omelet—asparagus
27. Baked potato
28. ———
29. **Sliced tomato salad**
30. **Mayonnaise dressing**
31. **Butter pecan ice cream—sugar cookies (‡303)**
32. Canned fruit cup
33. Vanilla ice cream
34. Fresh or frozen pineapple
35. Pineapple juice
36. **Bread**

January 12

1. **Grapefruit**
2. Orange juice
3. **Farina or bran flakes**
4. **Soft cooked egg**
5. Link sausages
6. **Pecan rolls (‡88)**

7. **Beef bouillon (‡29)**
8. **Saltines**
9. **Roast leg of veal with dressing**
10. Roast leg of veal
11. **Paprika potatoes**
12. Paprika potatoes

‡ Arabic numerals indicate page on which recipe may be found in "Large Quantity Recipes," by Margaret E. Terrell, Philadelphia, J. B. Lippincott, $7.

Ocean Spray Fresh Cranberries

FOR CHRISTMAS CRANBERRY-ORANGE RELISH

EASY TO MAKE:
(No cooking!)

Use 2 lbs. Ocean Spray Fresh Cranberries to 4 oranges (quartered, with seeds removed). Put through food chopper and add 2 lbs. sugar. Chill and serve. Serves 25.

Tart yet sweet, crisp yet juicy, Fresh Ocean Spray Cranberry-Orange Relish is delicious.

3 WAYS TO SERVE IT . . .

1. As a **RELISH** . . . Delicious with chicken, turkey, on sandwich or salad plates. Popular for relish trays.
2. **IN SALAD** . . . Fold into raspberry or strawberry gelatin to make delicious molded salad. Add nuts and celery if desired.
3. **DESSERT** . . . Fold into softened vanilla ice cream and refreeze in cookie crumb-lined pie plate for "Cranberry Ice Cream Pie."

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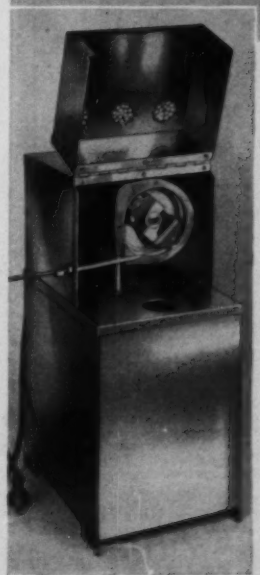

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13. **Broccoli with Hollandaise sauce**
14. Diced yellow squash
15. **Stuffed prune salad with cherry garnish**
16. **Maraschino French dressing**
17. **Pumpkin chiffon pie** (‡325)
18. Pumpkin chiffon pudding
19. Raspberry sponge
20. Unsweetened canned boysenberries
21. Blended citrus juice

22. **French tomato soup**
23. **Croutons**
24. **Hamburg creole with biscuits** (‡124)
25. Broiled beef pattie—sliced beets
26. Broiled beef pattie—asparagus
27. Whipped potatoes
28. ———
29. **Escarole and julienne beet salad**
30. **Vinaigrette dressing**
31. **Home style peaches**
32. Home style peaches
33. Lemon rennet-custard
34. Unsweetened canned peaches
35. Fruitade
36. **Cornbread** (‡75)

January 13

1. **Anjou pear**
2. Blended citrus fruit juice
3. **Corn flakes or brown granular wheat cereal**
4. **Scrambled egg**
5. Bacon
6. **Toast**

7. **Cream of asparagus soup** (‡35)
8. **Croutons**
9. **Baked white fish fillets**
10. Baked white fish fillets
11. **Mashed potatoes**
12. Riced potatoes
13. **Sliced carrots**
14. Beet greens
15. **Iced celery curls and radishes**
16. ———
17. **Gingerbread upside-down cake**
18. Floating island
19. Strawberry gelatin cubes
20. Unsweetened canned apricots
21. Grapefruit juice

22. **Clam chowder** (‡38)
23. **Oyster crackers**
24. **Eggs a la goldenrod on half baked potato**
25. Eggs a la goldenrod in toast cups
26. Cottage cheese on lettuce
27. Stuffed baked potato
28. **Green beans**
29. **Tomato quarters and cress salad**
30. **Russian dressing** (‡243)
31. **Cranberry betty**
32. Applesauce
33. Floating island
34. Orange sections
35. Apricot nectar
36. **Bread**

January 14

1. **Orange juice**
2. Grapefruit juice
3. **Oatmeal or wheat flakes**
4. **Poached egg**
5. Bacon
6. **Popovers**

7. **Beef broth**
8. **Crisp crackers**
9. **Country fried liver and bacon**
10. Broiled liver
11. **Creamed potatoes**
12. Baked potato
13. **Green peas**
14. Green peas
15. **Apricot and marshmallow salad**
16. **Cream mayonnaise**
17. **Gold layer cake**
18. Cherry sponge with custard sauce
19. Cherry sponge
20. Unsweetened canned peaches
21. Blended citrus juice

22. **Cream of potato soup** (‡47)
23. **Saltines**
24. **Caramel ham loaf** (‡149)
25. Baked cheese sandwich
26. Broiled lamb chop
27. Riced potatoes (omit on Soft Diet)
28. **Spinach**
29. **Lettuce wedge**
30. **Russian dressing**
31. **Fruit cup**
32. Sliced bananas in orange juice
33. Soft custard
34. Unsweetened fruit cup
35. Grapeade
36. **Hot rolls**

January 15

1. **Tangerines**
2. Blended citrus juice
3. **Shredded wheat or farina**
4. **Scrambled egg**
5. Grilled Canadian bacon
6. **Coffee cake** (‡74)

7. **Consomme**
8. **Saltines**
9. **Roast rib of beef**
10. Roast rib of beef
11. **Whipped potatoes**
12. Whipped potatoes
13. **Cauliflower**
14. Sliced beets
15. **Fruit salad**
16. **Buttercup dressing** (‡237)
17. **Raspberry sherbet**
18. Raspberry sherbet
19. Raspberry sherbet (no cream)
20. Grapefruit sections
21. Orange juice

22. **Cream of corn soup** (‡41)
23. **Crisp crackers**
24. **Boneless turkey fricassee on rusk**
25. Boneless turkey fricassee
26. Boneless turkey fricassee
27. Steamed new potatoes
28. **Asparagus tips**
29. **Fresh pineapple fan and strawberry salad**
30. **French dressing**
31. **Chocolate cup cakes**
32. Prune whip
33. Cherry gelatin
24. Unsweetened canned plums
35. Grapefruit juice
36. **Bread**

January 16

1. **Grapefruit**
2. Apricot nectar with lemon juice
3. **Rolled wheat or crisp rice cereal**
4. **Poached egg**
5. Bacon
6. **Toast**

7. **Beef bouillon** (‡29)
8. **Crisp crackers**
9. **Stuffed pork chop**
10. Baked veal chop
11. **Parsley potatoes**
12. Noodles
13. **Stewed tomatoes**
14. Green beans
15. **Apple, raisin and celery salad**
16. **Cream mayonnaise**
17. **Baked coconut custard**
18. Baked custard
19. Lemon and lime gelatin cubes
20. Fresh apple
21. Tomato juice

22. **Pepper pot soup** (‡46)
23. **Saltines**
24. **Creamed chipped beef**
25. Minced beef
26. Broiled steak
27. Baked potato
28. **Green peas**
29. **Head lettuce salad**
30. **Thousand Island dressing**
31. **Cherry crisp**
32. Pear in cherry gelatin
33. Baked custard
34. Unsweetened canned cherries
35. Orange juice
36. **Potato rolls** (‡88)

January 17

1. **Banana**
2. Pineapple juice
3. **Corn flakes or brown granular wheat cereal**
4. **Soft cooked egg**
5. Link sausages
6. **Bran muffins** (‡67)

7. **Chicken broth**
8. **Saltines**
9. **Roast leg of lamb**
10. Roast lamb
11. **Mashed potatoes**
12. Riced potatoes
13. **Sauteed parsnips**
14. Asparagus tips
15. **Raw vegetable salad bowl**
16. **Russian dressing** (‡243)
17. **Butterscotch sundae**
18. Chocolate sundae
19. Lemon ice
20. Fresh pineapple cup
21. Apricot nectar

22. **Vegetable soup** (‡34)
23. **Crisp crackers**
24. **Chicken and rice casserole** (‡159)
25. Creamed chicken
26. Hot sliced chicken
27. Fluffy rice
28. **Sliced carrots**
29. **Grapefruit and romaine salad**
30. **Clear French dressing**
31. **Prune cake with seafoam frosting** (‡269, 283)
22. Canned Royal Anne cherries
33. Vanilla rennet-custard
34. Fresh pear
35. Cranberry juice
36. **Bread**

January 18

1. **Sliced oranges**
2. Tomato juice
3. **Farina or bran flakes**
4. **Poached egg**
5. Bacon
6. **Toast**

7. **Essence of celery soup**
8. **Crisp crackers**
9. **Brown fricassee of veal** (‡152)
10. Veal patties
11. **Baked sweet potato**
12. Parsley potatoes
13. **Broccoli with lemon butter**
14. Sliced beets
15. **Cranberry salad** (‡216)
16. **Cream mayonnaise**
17. **Apricot cobbler with whipped cream** (‡353)
18. Baked custard with apricot puree
19. Pineapple whip
20. Unsweetened canned apricots
21. Blended citrus juice

22. **Corn chowder** (‡41)
23. **Oyster crackers**
24. **Beef biscuit roll** (‡126)
25. Beef biscuit roll
26. Cold roast beef
27. Riced potatoes
28. **Green peas**
29. **Cabbage, carrot and green pepper salad**
30. **Olive French dressing**
31. **Grapenut lemon puff** (‡341)
32. Orange sections
33. Lemon chiffon pudding
34. Unsweetened canned boysenberries
35. Cherry nectar
36. **Corn muffins** (‡69)

January 19

1. **Stewed fruit compote**
2. Blended citrus juice
3. **Puffed wheat or oatmeal**
4. **Scrambled egg**
5. Bacon
6. **Toast**

7. **Tomato bouillon**
8. **Cheese crackers**
9. **Country fried steak**
10. Broiled steak
11. **Whipped potatoes**
12. Whipped potatoes
13. **Glazed onions or carrots**
14. Quartered carrots
15. **Sliced lettuce salad**
16. **Thousand Island dressing**
17. **Baked apple tapioca with whipped cream**
18. Baked apple tapioca with whipped cream (‡350)
19. Strawberry gelatin
20. Unsweetened canned fruit cocktail
21. Grapefruit juice

22. **Cream of mushroom soup** (‡44)
23. **Melba toast**
24. **Scalloped potatoes with ham—watermelon pickle**
25. Broiled lamb chop
26. Broiled lamb chop
27. Lattice sliced potatoes
28. **Fresh spinach**
29. **Layer orange cottage cheese salad**
30. **French dressing**
31. **Peppermint ice cream**
32. Coffee gelatin
33. Coffee gelatin
34. Unsweetened canned plums
35. Pineapple juice
36. **Bread**

January 20

1. **Grapefruit**
2. Grapefruit juice
3. **Farina or wheat and barley kernels**
4. **Soft cooked egg**
5. Bacon
6. **Sally Lunn** (‡81)

7. **Southern bisque** (‡51)
8. **Saltines**
9. **Broiled halibut steak**
10. Broiled halibut steak
11. **Mashed potatoes**
12. Riced potatoes
13. **French style green beans**
14. French style green beans
15. **Cole slaw**
16. **Sour cream dressing**
17. **Lemon chiffon pie** (‡324)
18. Vanilla blanc mange, cherry juice sauce
19. Cherry sponge
20. Unsweetened canned dark cherries
21. Orange juice

22. **Cream of spinach soup** (‡49)
23. **Toast sticks**
24. **Tuna fish salad—potato chips**
25. Creamed tuna fish—peas
26. Low fat tuna on lettuce with lemon—peas
27. Baked potato
28. ———
29. **Carrot sticks—radishes**
30. ———
31. **Pineapple chunks—oatmeal cookies** (‡295)
32. Raspberry gelatin with sliced bananas
33. Vanilla blanc mange with cherry juice
34. Fresh pineapple
35. Apricot nectar
36. **Parker House rolls**

January 21

1. **Orange juice**
2. Orange juice
3. **Crisp rice cereal or rolled wheat**
4. **Scrambled egg**
5. Link sausages
6. **Toast**

7. **Ruby consomme** (‡32)
8. **Crisp crackers**
9. **Broiled lamb chop**
10. Broiled lamb chop
11. **Creamed whole potatoes**
12. Parsley potatoes
13. **Green Lima beans**
14. Latticed beets
15. **Jellied cider fruit salad** (‡215)
16. **Mayonnaise**
17. **Lemon snow with custard sauce**
18. Lemon snow with custard sauce
19. Lemon snow
20. Unsweetened canned peaches
21. Lemonade

22. **Pineapple juice with raspberry sherbet**
23. ———
24. **Veal Rosettes** (‡154)
25. Bacon curls—asparagus
26. Broiled beef patties—asparagus
27. Baked sweet potato
28. **Baked sweet potato**
29. **Head lettuce salad**
30. **Chiffonade dressing** (‡238)
31. **Chocolate marshmallow roll**
32. Peppermint ice cream
33. Baked custard
34. Unsweetened fruit compote
35. Chicken bouillon
36. **Bread**

January 22

1. **Tomato juice**
2. Tomato juice
3. **Oatmeal or corn flakes**
4. **Poached egg**

‡ Arabic numerals indicate page on which recipe may be found in "Large Quantity Recipes," by Margaret E. Terrell, Philadelphia, J. B. Lippincott, $7.

Another
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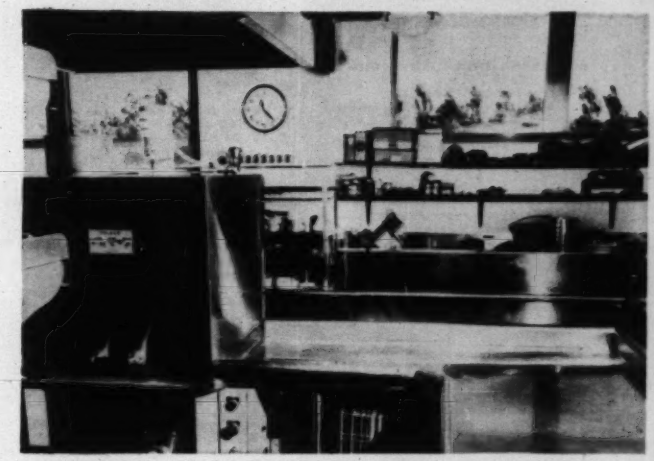

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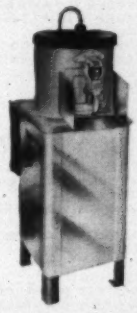

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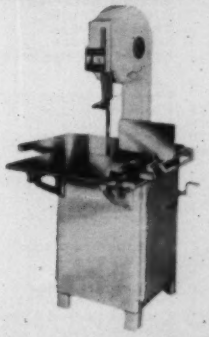

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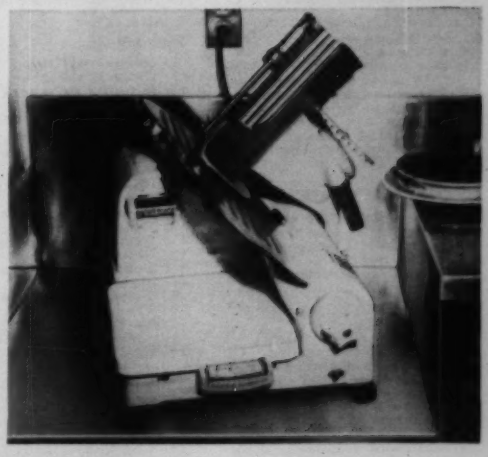

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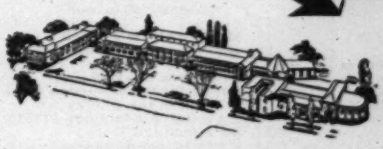

TREADWAY INN, ROCHESTER, N. Y.

ST. CHARLES HOSPITAL, TOLEDO, O.

CHERRY HILL INN, HADDONFIELD, N. J.

5. Bacon
6. **Raisin toast**

7. **Consomme**
8. **Saltines**
9. **Fried chicken** (‡155)
10. Broiled chicken
11. **Baked potato**
12. Baked potato
13. **Fresh spinach**
14. Fresh spinach
15. **Apricot au natural salad**
16. **Cream mayonnaise**
17. **Chocolate chip ice cream**
18. Chocolate chip ice cream
19. Raspberry ice
20. Half grapefruit
21. Grapefruit juice

22. **Cream of pea soup**
23. **Crisp crackers**
24. **Fluffy cheese-rice omelet** (‡102)
25. Fluffy cheese-rice omelet
26. Cottage cheese on lettuce
27. Noodles (omit on Soft Diet)
28. **Green beans**
29. **Sliced orange salad**
30. **Parisian dressing**
31. **Angel food cake** (‡275)
32. Canned peaches—angel food cake
33. Chocolate rennet-custard
34. Unsweetened canned pear
35. Cranberry juice
36. **Bread**

January 23

1. **Grapefruit**
2. Grapefruit juice
3. **Bran flakes or farina**
4. **Soft cooked egg**
5. Bacon
6. **Biscuits**

7. **Mushroom bouilion**
8. **Whole wheat wafers**
9. **Meat loaf** (‡127)
10. Meat pattie
11. **Scalloped potatoes**
12. Parsley potatoes
13. **Paprika cauliflower**
14. Julienne carrots
15. **Pear and stuffed date salad**
16. **Mayonnaise**
17. **Apple cheese crisp** (‡347)
18. Apple cheese crisp
19. Pineapple whip
20. Minted fresh pineapple cup
21. Limeade

22. **Mulligatawny soup** (‡44)
23. **Saltines**
24. **Hot pork sandwich—peas in mashed potato nests**
25. Minced turkey casserole with potato topping—peas
26. Hot sliced turkey
27. Riced potatoes (omit on Soft Diet)
28. ———
29. **Celery hearts and radishes**
30. ———
31. **Fresh pineapple cupcakes**
32. Pear in lime gelatin
33. Lime gelatin cubes
34. Fresh pear
35. Mixed fruit juice
36. ———

January 24

1. **Blended citrus juice**
2. Blended citrus juice
3. **Brown granular wheat cereal or crisp rice cereal**
4. **Scrambled egg**
5. Bacon
6. **Toast**

7. **Julienne vegetable soup**
8. ———
9. **Baked breaded veal cutlet**
10. Baked liver
11. **Potatoes with parsley cream sauce**
12. Baked potato
13. **Spiced beets**
14. Sliced beets
15. **Carolina salad (apple, cabbage and raisin)** (‡212)
16. **Sour cream dressing**
17. **Custard pie**
18. Peach floating island
19. Whipped lemon gelatin
20. Unsweetened canned apricots
21. Orange juice

22. **Cream of carrot soup**
23. **Melba toast**
24. **Spanish meat balls** (‡128)
25. Meat and rice balls, tomato puree sauce
26. Cold roast lamb
27. Baked sweet potato
28. **Fresh spinach**
29. **Tangerine and grapefruit salad**
30. **French dressing**
31. **Crackers, cream cheese, guava jelly**
32. Applesauce
33. Floating island
34. Unsweetened Royal Anne cherries
35. Cranberry juice
36. **Hot rolls**

January 25

1. **Sliced oranges**
2. Orange juice
3. **Wheat flakes or oatmeal**
4. **Soft cooked egg**
5. Grilled ham
6. **Raisin bread toast**

7. **Tomato bouilion**
8. **Saltines**
9. **Turkey creole**
10. Roast turkey
11. **Steamed rice**
12. Steamed rice
13. **Asparagus tips**
14. Asparagus tips
15. **Frozen fruit salad**
16. ———
17. **Chocolate cake squares** (‡262) **with mocha icing** (‡280)
18. Chocolate cake squares
19. Mocha sponge
20. Grapefruit sections
21. Grapefruit juice

22. **Oyster bisque** (‡45)
23. **Oyster crackers**
24. **Meat casserole** (‡143)
25. Cottage cheese on lettuce
26. Cottage cheese on lettuce
27. Stuffed baked potatoes
28. **Quartered carrots**
29. **Celery sticks**
30. ———
31. **Canned boysenberries**
32. Canned fruit cup
33. Baked custard
34. Unsweetned fruit cocktail
35. Fruitade
36. **Butterscotch pecan biscuits** (‡65)

January 26

1. **Grapefruit juice**
2. Grapefruit juice
3. **Hominy or wheat and barley kernels**
4. **Poached egg** (omit on Normal Diet)
5. Link sausages
6. **French toast with syrup**

7. **Consomme**
8. **Crisp crackers**
9. **Roast leg of lamb** (‡139)
10. Roast leg of lamb
11. **French fried potatoes**
12. Paprika potato balls
13. **Tomatoes and pearl onions**
14. Mashed squash
15. **Tossed green salad**
16. **Vinegar-oil dressing**
17. **Chilled pear half with cranberry sherbet**
18. Chilled pear half with custard sauce
19. Cranberry sherbet (no cream)
20. Delicious apple
21. Orange juice

22. **Chicken soup** (‡40)
23. **Saltines**
24. **Sweet potato and apple scallop—Canadian bacon** (‡116)
25. Creamed chicken and noodles—green peas
26. Baked veal chop—green peas
27. Noodles (omit on Soft Diet)
28. ———
29. **Cabbage and green pepper salad**
30. **Sour cream dressing**
31. **Baked custard**
32. Canned peaches
33. Baked custard
34. Unsweetened canned peaches
35. Pear nectar
36. **Bread**

January 27

1. **Stewed fruit compote**
2. Blended citrus juice
3. **Corn flakes or rolled wheat**
4. **Scrambled egg**
5. Bacon
6. **Toast**

7. **Spring soup** (‡52)
8. **Saltines**
9. **Haddock fillets**
10. Baked haddock
11. **Mashed potatoes**
12. Cubed potatoes
13. **Green Lima beans**
14. Chopped spinach
15. **Pineapple and cottage cheese salad** (‡220)
16. ———
17. **Banana shortcake with whipped cream** (‡351)
18. Grape sponge with whipped cream
19. Grape sponge
20. Unsweetened fruit compote
21. Grapefruit juice

22. **Rhode Island clam chowder** (‡37)
23. **Oyster crackers**
24. **Fruit salad—cream cheese sandwich**
25. Omelet—sliced beets
26. Omelet—sliced beets
27. Baked potato
28. ———
29. **Raw vegetable relish plate**
30. ———
31. **Baked cherry rhubarb—peanut butter cookies** (‡284)
32. Banana and orange cup
33. Vanilla blanc mange with apricot nectar
34. Banana and orange cup
35. Pineapple juice
36. ———

January 28

1. **Orange halves**
2. Orange juice
3. **Oatmeal or puffed wheat**
4. **Soft cooked egg**
5. Bacon
6. **Whole wheat date muffins**

7. **Beef noodle soup**
8. **Crisp crackers**
9. **Pot roast of beef**
10. Pot roast of beef
11. **Mashed potatoes**
12. Riced potatoes
13. **Turnip greens**
14. Sliced carrots
15. **Grapefruit and cranberry salad**
16. ———
17. **Floating island** (‡339)
18. Floating island
19. Lime gelatin
20. Fresh pineapple
21. Tomato juice

22. **Split pea soup** (‡46)
23. **Croutons**
24. **Shepherd's pie**
25. Lamb patties
26. Lamb patties
27. Whipped potatoes
28. **Green beans**
29. **Tomato salad**
30. **French dressing**
31. **Peach cobbler** (‡354)
32. Canned peeled apricots
33. Whipped jello
34. Unsweetened canned apricots
35. Apple juice
36. **Bread**

January 29

1. **Banana**
2. Blended fruit juice
3. **Shredded wheat or farina**
4. **Scrambled egg**
5. Link sausages
6. **Coffee cake** (‡74)

7. **Consomme**
8. **Saltines**
9. **Baked Virginia ham** (‡146)
10. Roast chicken
11. **Mashed potatoes**
12. Riced potatoes
13. **Green peas**
14. Green peas
15. **Waldorf salad** (‡215)
16. ———
17. **Strawberry ice cream**
18. Raspberry ice
19. Raspberry ice
20. Unsweetened canned cherries
21. Grapefruit juice

22. **Onion-tomato soup**
23. **Crisp crackers**
24. **Assorted cold cuts—marinated cooked vegetable salad**
25. Minced beef sandwich—peach half on tender lettuce
26. Cold sliced beef—hot spiced beets
27. Spinach
28. ———
29. **Stuffed celery**
30. ———
31. **Sponge cake with whipped cream** (‡262)
32. Sliced banana in apricot nectar
33. Baked custard
34. Fresh pineapple
35. Mixed fruit juice
36. **Rye bread**

January 30

1. **Orange juice**
2. Orange juice
3. **Brown granular wheat cereal or corn flakes**
4. **Poached egg**
5. Grilled ham
6. **Toast**

7. **Beef bouillon** (‡29)
8. **Crisp crackers**
9. **Veal birds with mushroom sauce** (‡152)
10. Baked veal steak
11. **Scalloped potatoes**
12. Noodles
13. **Glazed carrots**
14. Sliced carrots
15. **Perfection salad** (‡224)
16. **Horse-radish salad dressing** (‡240)
17. **Caramel pecan pie** (‡313)
18. Canned fruit gelatin
19. Strawberry gelatin
20. Unsweetened canned fruit cocktail
21. Blended citrus juice

22. **Chicken giblet soup with rice** (‡30)
23. **Saltines**
24. **Asparagus on toast with cheese sauce—bacon atop**
25. Welsh rarebit on toast—bacon atop—asparagus
26. Beef pattie—asparagus
27. Baked potato
28. ———
29. **Grapefruit and red apple salad** (‡214)
30. **French dressing**
31. **Prune whip** (‡360)
32. Prune whip
33. Raspberry rennet-custard
34. Unsweetened canned plums
35. Pineapple juice
36. **Bread**

January 31

1. **Blended citrus juice**
2. Blended citrus juice
3. **Wheat flakes or oatmeal**
4. **Soft cooked egg**
5. Bacon
6. **Corn muffins** (‡68)

7. **Tomato bouillon**
8. **Melba toast**
9. **Braised liver**
10. Broiled liver
11. **Paprika potatoes**
12. Paprika potatoes
13. **Fried eggplant**
14. Spinach with lemon
15. **Head lettuce salad**
16. **Savory dressing** (‡243)
17. **Applesauce cake with lemon icing** (‡260)
18. Pineapple whip with custard sauce
19. Pineapple whip (‡367)
20. Unsweetened canned peaches
21. Orange juice

22. **Lentil soup** (‡42)
23. **Crisp crackers**
24. **Turkey-macaroni casserole**
25. Turkey-macaroni casserole
26. Hot sliced turkey—whipped potatoes
27. ———
28. **Diced yellow squash**
29. **Cabbage, carrot and green pepper salad**
30. **Tarragon dressing**
31. **Fresh fruit cup—corn flake macaroons** (‡293)
32. Baked apple tapioca (‡350)
33. Soft custard
34. Unsweetened canned pears
35. Cherry nectar
36. **Oatmeal rolls**

‡ Arabic numerals indicate page on which recipe may be found in "Large Quantity Recipes," by Margaret E. Terrell, Philadelphia, J. B. Lippincott, $7.

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What It's Like to Work in a Hospital

THE GIVE AND TAKE IN HOSPITALS; A STUDY OF HUMAN ORGANIZATION. Temple Burling, M.D., Edith M. Lentz and Robert N. Wilson. New York, Putnam, 1955. $4.75

This report on research initiated by the American Hospital Association and conducted by the Cornell University School of Industrial Relations is aimed at clarifying the problems of supervisory training and employee motivation in the hospital. By all odds, it is the most substantial contribution of our day to this ancient but relatively unexplored area of administration.

Throughout the hospital there has been a long and insistent cry for greater understanding. Nurses want understanding from the physician, the administrator and all other hospital personnel. Hospital engineers, too, feel that others in the hospital plant do not fully comprehend their working problems. And hospital administrators repeatedly stress this need for understanding by physicians, hospital personnel and their board, not only of the administrator's immediate problems but fundamentally of the whole operation of the hospital. Finally, all in the hospital field continually talk about the need for public knowledge of the complexities of hospital administration.

To reach the core of such needed knowledge, the study staff from Cornell has spent many man hours in each department of the hospital, talking to the individual hospital employee at all levels and to board members and physicians. With this broad range of information they have written a report which gives all of those concerned in any way with the hospital a clear conception of what it is like to work there and what some of the problems are that confront those involved with hospital service.

Thus, this book will certainly enlighten everyone who reads it, whether the reader is an experienced hospital administrator or the newest member of the women's hospital auxiliary. It should be broadly read by laymen interested in the hospital, by hospital board members and staff and physicians. The net result will be greater coöperation among all the groups concerned with care of the patient.

Certainly this study report becomes an important teaching resource for all the schools which prepare people for work in the hospital — schools of medicine, nursing, hospital administration and other paramedical specialties. It should also be valuable in the schools of public health and for other groups, such as Blue Cross Plans, having programs related to the hospital.

This report, obviously, can offer no quick solution to better hospital operation. But it does point toward refinements in our working together to continually improve the care of sick people. It is a volume which the hospital field has awaited for a long, long time.—GEORGE BUGBEE, *President, Health Information Foundation.*

Of persons, places and things

The year's end again offers the opportunity to review Library acquisitions of the past twelve months. The following list of fifty titles was chosen to show the scope of the Library's collection and to remind the reader of the complexity and breadth of hospital administration.

Some of the titles have merited reviews in "The Literature" section; a complete listing of books reviewed in 1955 will be found under "Book Reviews" in the annual index in this issue.

Three titles of this year's 50 do not fit the arbitrary classification by which the other titles are grouped:

Financing Hospital Care in the United States. Commission on Financing of Hospital Care. New York, Blakiston Co., 1954. 3 vols. $9.85.

American Men of Science. Jaques Cattell, editor. 9th ed. New York, Bowker, 1955. v.1, $12.75.

A History of Medicine. Ralph H. Major. Springfield, Ill., Thomas, 1954. 2 v. $14.50.

PERSONS: PERSONNEL, TRUSTEES AND VOLUNTEERS

Activities in Nursing Homes; Handbook for Volunteers. Kansas State Dept. of Social Welfare. Topeka, The Dept., 1955. 73 1.

How to Work with Your Board and Committees. Louis H. Blumenthal. New York, Association Press. 1954. 64 pp. $1.00.

Human Relations in Nursing. Wayland J. Hayes and Rena Gazaway. Philadelphia, Saunders, 1955. 471 pp. $4.50.

The Operating Room Supervisor at Work. Edna A. Prickett. New York, National League for Nursing, 1955. 112 pp. $1.50.

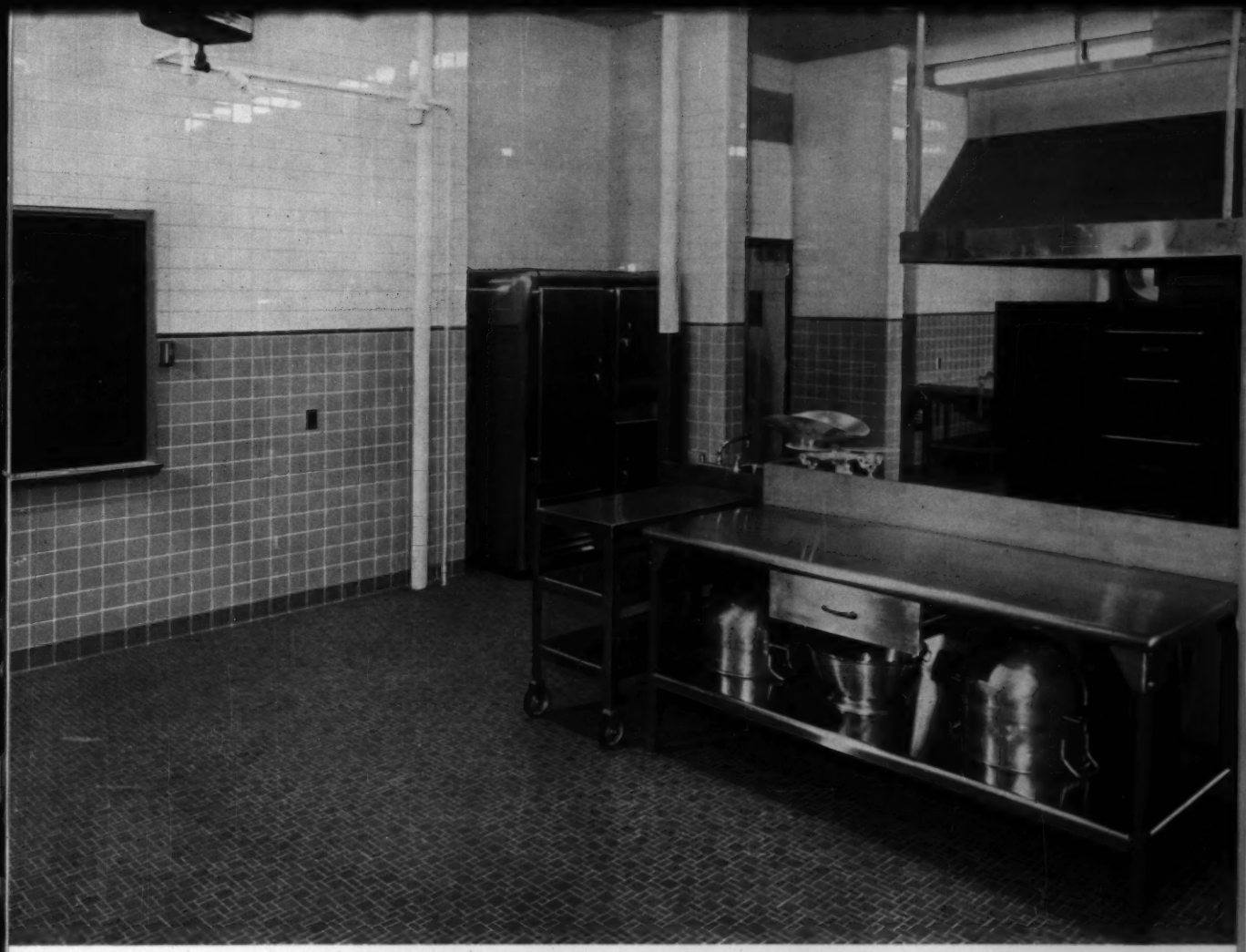
Patterns of Patient Care; Some Studies of the Utilization of Nursing Service Personnel. Frances L. George. New York, Macmillan, 1955. 266 pp. $4.50.

The Practical Nurse and Her Patient. Fern A. Goulding and Hilda M. Torrop. Philadelphia, Lippincott, 1955. 326 pp. $4.25.

Retirement of Employees. National Industrial Conference Board. New York, The Board, 1955. 48 pp. $2.

A Survey of the Organizational Structures and the Practices of Faculty Meetings in One Hundred and Twenty Schools of Nursing. Esther M. Longanecker. St. Louis, 1954. 71 1.

The Techniques of Supervision. Alfred R. Lateiner. New London,



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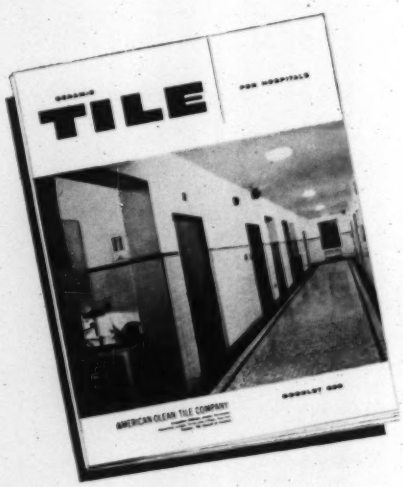

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- ☐ **Folder 501: Technical data, specifications, and installation, Conduct-O-Tile.**
- ☐ **Booklet 600: Tile for Hospitals.**

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Title_____

Hospital_____

Address_____

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Conn., National Foremen's Institute, 1954. 207 pp. $4.00.

Techniques that Produce Teamwork. Warren H. Schmidt and Paul Buchanan. New London, Conn., A. C. Croft, 1954. 75 pp. $2.50.

Working in a Mental Hospital; a Guide for Ward Personnel. National Association for Mental Health. New York, The Association, 1955. 86 pp. $.50.

PLACES: HEALTH FACILITIES

Hospital Planning Requirements. Guy Aldis. London, Sir Isaac Pitman, 1954. 257 pp. $11.90.

Improvised Hospitals. U.S. Federal Civil Defense Administration. Washington, 1954. Mimeographed. 60 pp.

The Rural Hospital; Its Structure and Organization. R. F. Bridgman. Geneva, World Health Organization, 1955. 162 pp. $4.00.

A Survey of Union Health Centers. American Medical Association. Chicago, The Association, 1954. 46 pp.

THINGS: MANUALS, HANDBOOKS AND TEXTS

Anesthesiology Handbook. American Society of Anesthesiologists. Chicago, The Society, 1955. 64 pp.

Basic Medical Terms and Techniques Simplified. Minnie I. Paddock. Chicago, American Technical Society, 1955. 148 pp. $3.50.

The Hospital Formulary of Selected Drugs. Don E. Franke. Ann Arbor, Mich., University Hospital 1954. 759 pp. $5.

Fundraising Made Easy. Edwin S. Newman and Leo J. Margolin. New York, Oceana Publications, 1954. 158 pp. $2.50.

A Guide for Hospital Administration Training Programs in Public Health Service Hospitals. U.S. Public Health Service. Washington, 1952. 42 pp.

Hospital Emergency Defense. Robert McGrath. Chicago, Chicago Civil Defense Corps, 1955. 26 pp.

How to Become a Better Reader. Paul Witty. Chicago, Science Research Associates, 1953. 304 pp. $5.00.

Indexing Your Book; a Practical Guide for Authors. Sina Spiker. Madison. University of Wisconsin Press, 1954. 28 pp. $.50.

Introduction to Operating-Room Technique. Edna C. Berry and Mary Louise Kohn. New York, McGraw-Hill, 1955. 154 pp. $4.00.

Manual for Georgia Hospitals in Civil Defense. Georgia Dept. of Public Health. Atlanta, 1954. 45 pp.

Manual of Hospital Purchasing and Inventory Control. E. C. Wolf. Minneapolis, Burgess, 1955. 143 pp. $4.00.

Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Blood Vessels. 5th ed. New York Heart Association, Inc. New York, 1953. 359 pp. $4.55.

Nutrition and Diet Therapy. Fairfax T. Proudfit and Corinne H. Robinson. 11th ed. New York, Macmillan, 1955. 859 pp. $5.25.

Organization and Administration of Blood Banks. American Association of Blood Banks. Dallas, The Association, 1954. 114 pp. $4.00.

Plain Letters. U.S. National Archives and Records Service. Records Management Division. Washington, Government Printing Office, 1955. 47 pp. $.30.

ETHICS, MORALS AND RELIGION

A Guide for Conduct of Radiologists in Relationships with Institutions. American College of Radiology. Chicago, The College, 1955. 23 pp.

Morals and Medicine. Joseph F. Fletcher. Princeton, N.J., Princeton University Press, 1954. 253 pp. $4.50.

Patron Saints of Catholic Hospitals. Catholic Hospital Association. St. Louis, Mo., The Association, 1955. 31 pp.

HEALTH AND WELFARE

Digest of One-Hundred Selected Health and Insurance Plans under Collective Bargaining, 1954. U.S. Dept. of Labor, Bureau of Labor Statistics. Washington, U.S. Government Printing Office, 1955. 208 pp. $1.00.

Expanding Horizons in Medical Social Work. Dora Goldstine, ed. Chicago, University of Chicago Press, 1955. 274 pp. $5.00.

Fact Book on Aging. U.S. Federal Security Agency. Washington, U.S. Government Printing Office, 1952. 62 pp. $.30.

Grant and Award Programs. U.S. National Institutes of Health. Bethesda, Md., 1955. 22 pp.

Infant Care. U.S. Children's Bureau. Washington, U.S. Government Printing Office, 1955. 106 pp. $.15.

An Inventory of Social and Economic Research in Health. Health Information Foundation. New York, The Foundation, 1955. 266 pp.

A Model State Medico-Legal Investigative System. National Municipal League. 2d ed. New York, The League, 1954. 40 pp. $.50.

Needed Research in Health and Medical Care. Cecil G. Sheps. Chapel Hill, University of North Carolina Press, 1954. 216 pp. $5.00.

A Study of Multiple Screening; Descriptive Data on 33 Screening Surveys. American Medical Association, Council on Medical Service. Chicago, 1955. 91 pp.

Studying Your Community. Roland L. Warren. New York, Russell Sage Foundation, 1955. 385 pp. $3.00.

Suburbanitis; a Growing Problem for Social Welfare. Community Chests and Councils of America. New York, The Chests, 1954. 20 1.

MORBIDITY AND MORTALITY

Age and Sex Distribution of Hospital Patients. Frank G. Dickinson. Chicago, American Medical Association, 1955. 24 pp.

Mortality from Each Cause, United States, 1951-53. U.S. National Office of Vital Statistics. Washington, U.S. Government Printing Office, 1955.

Sickness Experience in Selected Areas of the United States. Selwyn D. Collins and others. Washington, U.S. Government Printing Office, 1955. 96 pp. $.50.

Large-scale buying

GOVERNMENT PURCHASING AND COMPETITION. Dickson Reck. Berkeley, University of California Press, 1954. 215 pp. $4.

This study is based on the concept that large-scale buyers, such as governments, institutions and large industrial and commercial firms, can substantially improve the effectiveness of their purchasing policies by using better methods of specifying products, inviting bids, evaluating quality and price and awarding contracts.

Although the book deals with government purchasing, which does limit its application to hospitals somewhat, there is still much of value in it for large-scale buyers. Certainly many of the practices are not applicable, but these can be modified and used as a guide by the individual hospital.—JOSEPH A. WILLIAMSON, *assistant secretary, Council on Administrative Practice.*

purchasing

purchasing for occupational therapy

MAJOR RUTH A. ROBINSON, AMSC

"IN DETERMINING THE scope of occupational therapy," writes Henrietta McNary,[1] "the types of human problems and the range of activities that might be helpful in these problems must be considered. The numberless procedures that may be useful therapeutically make the field boundless except as it is limited by the need to direct the undertaking specifically toward the solution of the problems of the individual patient . . . The activity, as we all know, is secondary, and is used as a means to an end."

Activity is the means. Most of our activities require equipment and supplies. Items must be purchased, and there lies one of our most vital administrative functions —purchasing.

Purchasing is a rather formal term when it refers to the procurement of occupational therapy supplies and equipment. We deal with color and texture; with lumber, leather, silver and copper; with paints, brushes and tools. Then, too, most occupational therapists are women. Women are said to love to shop, so one might suppose most of us would enjoy purchasing. We don't.

This means perhaps we should ask ourselves some questions. For example, is our attitude wrong? Are we uncertain of what we are doing? Have we ever taken enough time to initiate a workable purchasing system? It might be well to review some of the basic facts and methods of purchasing.

Major Robinson is chief of the Occupational Therapy Section Walter Reed Army Hospital, Washington, D. C. This article is from the text of an address by the author to the recent American Hospital Association Institute for Occupational Therapists.

1. Willard, Helen, and Spackman, Clare, *Principles of Occupational Therapy.*

Let's start off by assuming that you already have submitted your estimated budget. After a suitable lapse of time, you are informed of approximately how much money your department will be allocated for the fiscal year. We will further assume that this amount may fluctuate during the year with the size of your patient load, and that you will order periodically rather than continuously. Quarterly requisitions are by far the most satisfactory if you can manage such an arrangement. Periodic purchasing is economically sound since it encourages—in fact, demands—good planning. It eliminates a good deal of the clerical work and permits quantity buying with those ever-welcome discounts.

Your hospital probably has a purchasing agent, and your requisitions are submitted to him for necessary action. He may be hesitant about purchasing occupational therapy supplies since he knows nothing about them, but keep in mind that it is your responsibility to inform him. Since you are a specialist in your field, he will respect your knowledge and judgment. In time, he will learn from you and you from him. Remember, he is there to help you, not to hinder you; he can be one of the best friends you have in the hospital.

The first thing you should do is to resurvey your equipment. Naturally, when you estimated the budget you considered new pieces of equipment needed by the department, as well as the cost of items that will need to be replaced during the year. You took into account the policy of your hospital on the purchase of replacement parts—whether these are bought from the general maintenance fund or from funds allocated to the department.

After you have determined what equipment you will need, select those items most urgently needed and plan to purchase them first. You should try not to use more than one-fourth of the amount you estimated for the year. That way, you order only what you actually must have. And your needs probably will change; if you do not plunge all at once, you will still have funds available. Naturally, this does not hold with a large, one-item purchase. Determination of what is a "large" purchase depends on the size of your budget—perhaps 10 per cent of a good sized budget, 20 per cent of a small budget.

Supplies are next for consideration. With the purchasing agent, you have checked the list of general items used in the hospital which are needed by your department. You have informed him what and how much you will need through the year.

Now, at last, you may consider those items used only in occupational therapy. You know your case load, the types of diagnoses you treat and the activities you have. You know the types of materials you need, the colors and the amounts you use. If you cannot tell from your records how much of each item was purchased during the past two years, what the cost was, how much you used and how much you still have on hand, you had better get busy. (Incidentally, to get the amount on hand just count what is left—for operations

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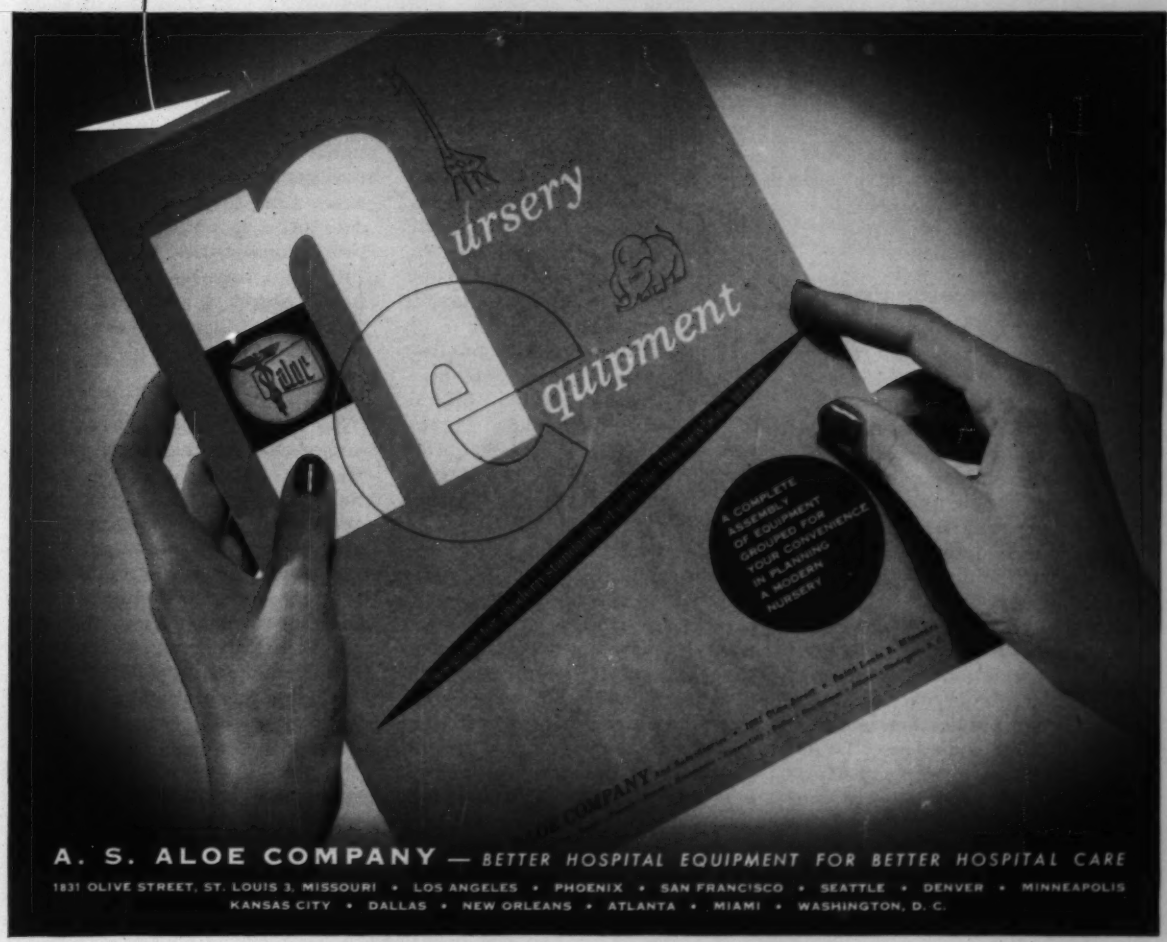

A. S. ALOE COMPANY — *BETTER HOSPITAL EQUIPMENT FOR BETTER HOSPITAL CARE*

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the size of most occupational therapy departments, it's quicker than keeping a running inventory.)

RECORDS SHOULD BE SIMPLE

Working records of this type are simple to keep and make the path smoother. A simple file card, even kept in pencil, will do the trick. The card should be headed with the item (for filing), then the specification, date the requisition was placed, suggested vendor, amount ordered, estimated cost per unit and the total cost. These should be followed by the date the item was received, the final unit cost (fluctuating market) and the firm from which the purchase was actually made.

Now that you know what you're going to order, the time has come to submit your requisitions. You follow the procedures established by your hospital, of course. Your friend the purchasing agent will be pleased to assist you if difficulties arise. He has visited your department, he knows your problems, he knows you must receive the items as specified. You understand his problems and the established policies as regards such points as ordering by brand name or securing bids. Let us hope that bids are required except in a few instances of proved merchandise, since bidding saves money.

WRITE GOOD SPECIFICATIONS

Next comes the matter of specification writing. You must really know what it is you want, and even so it takes time to write good specifications. Yet here is the basis of a good supply system. It demands that you shop, read and keep abreast of new items, changes in tried items, and market trends.

What is a good specification? It tells anyone familiar with a particular category of item the material, quality, type, size and color you wish to purchase. How do you get this information? By visiting local dealers, studying catalogs, reading trade publications and, of course, through experience. Dealers will be happy to help you. They are in business and helping you creates good will.

Let us consider a few sample items and their specifications:

Leather Belts. If you wish to purchase belt lengths suitable for carving, tooling and lacing, you must be sure that the leather will carve, tool and that not too much effort is required for punching. You must determine the length and width you want, the colors, the weight, the type of dye, the finish. Below are two specifications; one will bring an unwelcome surprise and one will result in the arrival of what I think you want.

POOR—Belt blanks, leather, 1″ wide, random lengths, 7-8 oz., suitable for carving.

GOOD—Belt blanks, leather, 1″ wide, random lengths, 7-8 oz., natural, dull finish, belt flesh, for tooling and carving.

Paint Brushes. If you wish to purchase brushes suitable for work with oils it behooves you to learn a little about them. Remember that they come in various shapes—"brights," which are flat and thin with short bristles arranged in a square edge; "flats," which are similar to "brights" but thicker and with longer bristles, and "rounds," the same length as "flats" but perfectly round with a pointed tip.

Remember, too, that there are two series of sizes, the smaller series often known as the "French" series. In general, French sizes are about one-half regular sizes. They run from 1 to 24 instead of 1 to 12. And brushes, like everything else, come in a number of grades. They come in bristle, red sable, Russian sable, ox hair and badger:

POOR—Brushes, white bristles, for oil painting, size #1, rounds.

GOOD—Brushes, white bristle, for oil painting, rounds, French size #2, bristle length ½″, fair quality bristle in tin ferrules on long, plain white handle. Quality equal to . . .

We could find many such illustrations, but these will serve to point out the need for care and accuracy if you are to get what you want. If you're not willing to spend time and effort before writing a new specification, you will always have trouble. Once it has been used and the item received has proved satisfactory you can continue to use the same specification each time you order.

You should make it clear to the purchasing agent that you must inspect all items before they are accepted to insure that the order has been filled correctly. Make it clear that you reserve the right to refuse unsatisfactory items. If one or a few 25-cent items arrive and are not what you thought you ordered, however, accept them. It costs too much to return them—just write a better specification next time.

AND OTHER MATTERS

In discussing these elementary steps, we have not gone into specific items you will order. I know you all realize the importance of buying good equipment, planning purchases with care and discretion and keeping alert to new ideas, materials and equipment. These alone probably will do you fairly well, but there are still a few other points I feel we should consider.

ROLE OF THE THERAPIST

A good purchasing system permits determination of the items to be purchased by those immediately concerned with their use. It is designed to eliminate duplication of effort, to simplify administrative work of the professional staff and to enforce good planning and wise utilization of funds. If the occupational therapist does the actual purchasing, she must sacrifice too much time to it; this is time she can spend to better advantage in professional duties. She must control what and how much is ordered, however, and have the authority to refuse improperly filled orders.

PURCHASING ROUTINES

In our discussion we have assumed that routines of the hospital will be followed or modified to meet the needs of occupational therapy. The items purchased will change, as will the amounts, but the structure should remain stable.

Records must be kept to serve as a guide to plan by and to use in estimating the budget. These records should apply to all items used, including general items procured for the hospital as a whole. You should attempt to keep track of the actual cost of supplies and equipment. It should be possible to obtain such cost figures from your bookkeeper, comptroller or purchasing agent.

I cannot stress this too strongly. It is important for you to be able

to calculate the average cost of a treatment. This necessarily includes salaries, supplies, equipment, maintenance of equipment and physical plant, heat, light, water. Many administrators still think of occupational therapy as a luxury, and only through records such as these can we show without a doubt that this service is within reach of the average hospital budget.

DONATIONS

It should be pointed out to your hospital administrator that occupational therapy cannot run on donations. Sometimes they are welcome; it all depends on what they are. If you must accept or even encourage donations, the types of items you can use should be clearly outlined; and it must be understood that many items will always have to be purchased. If donations are accepted, provision must be made for cleaning such things as used wool, felt and burlap. You cannot have patients working with soiled materials unless there is a therapeutic reason for, and a learning process in, cleaning or washing them for others to use.

MARK-UPS

This is a difficult subject and one which we possibly might be tempted to avoid; but since it is of interest to many of us, here goes.

You should not try to contribute too much to the financing of your department through resale of materials to patients. If you must do so, keep in mind the fact that it is always better to have the cost of a treatment cover the total cost and that the patient should be given materials needed for the treatment. If the patient is not able to pay for his hospitalization and occupational therapy as prescribed, the cost of materials cannot enter into the picture.

Here are a number of questions to consider:

1. Which items should not have a mark-up but should be sold at cost?
2. Which ones should have a mark-up?
3. Which should be given to the patient?
4. How much should the mark-up be?
5. Should fluctuation of prices be considered?
6. Should the patient be permitted or encouraged to purchase his own materials? (Since we wish to control activity to insure that the patient does not work beyond his capacity, private purchasing probably should be discouraged, especially in the case of cardiac and tuberculosis patients.)

One way to handle the mark-up problem is to use a small boost, perhaps 3 per cent, on all basic items, such as yarn, wood, plastic and leather. Give the patients the thread, varnish, leather dye, wax or sandpaper as they are needed.

Another way is to put a mark-up only on those items where there is waste, such as metal, wood, leather and plastic. Then there is no mark-up on leather lacing, yarn, silver wire, fabrics and the like.

A third way is to sell everything at cost and take losses on wood, leather, plastic. Then charge a minimal sum for small quantities of leather dye, shellac, wax, etc. Since you will purchase these items in large quantities, this can help to cover your losses. ■

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TOMAC Telescopic Cubicle Curtain attaches to wall or bed... swings away from bed for easy patient examination. Spring hinge (shown above) eliminates damage due to accidental pulling. When released, rod and curtain return to position. There's much less curtain to launder than with old-fashioned equipment.

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Hospital personnel will be happy to know that they no longer need be plagued by cubicle curtains and safety sides that are unwieldy, difficult to handle, and always in the way.

Continuing product research by American Hospital Supply has developed new TOMAC Cubicle Curtains and TOMAC Safety Sides that telescope conveniently and completely out of the way when not in use. They're lightweight—easy to operate—and ruggedly constructed for years of service. They are proving to be a boon to hospital personnel and patients.

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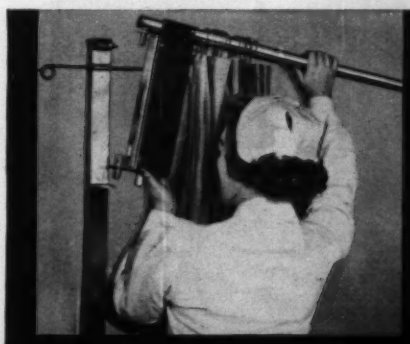
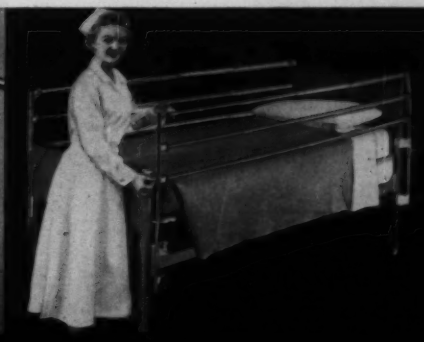


Telescopes to ⅓ its full length and folds flat against wall when not in use. Easily detached to be moved or stored. Strong, but slender, chromium unit. Linene curtains or Bates curtains are available in five harmonious pastel colors —white, rose, aqua, gray, or blue.



TOMAC Telescopic Safety Sides shown fully extended. Nurse is tightening thumb screw which holds sides securely. Lightweight and convenient, yet ruggedly constructed. Specially designed clamps allow TOMAC Safety Sides to be fitted to all standard beds.

Sides shown telescoped and folded back . . . chain catch prevents sides from opening. Easily and quickly attached without tools. They can be stored or can be left on bed ready for instant use (either at side or behind bed). Rubber bumper prevents marring of walls.

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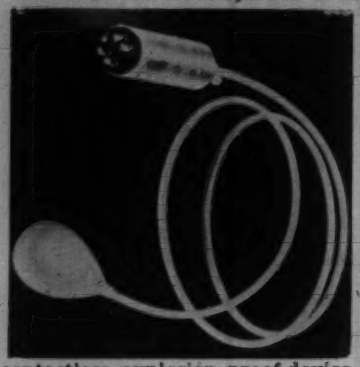
equipment and supply review

Signaling device (12B-1)

Manufacturer's Description: Signaling by patients in oxygen tents is made safe with the development of a



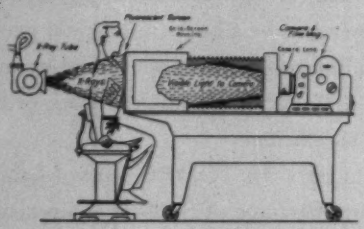
contactless, explosion-proof device. The locking button is constructed of non-conductive plastic, actuated with only slight hand pressure.

X-ray motion pictures (12B-2)

Manufacturer's Description: X-ray motion pictures, known technically as cinefluorography, will soon make their commercial debut. This unit equipment was developed and designed at the University of Rochester Medical Center.

The new apparatus has been designed for use with conventional x-ray equipment and can be used for taking pictures with the patient seated, standing or lying down. The picture taking area is 15" x 15". The device can be used with either 16 mm or 35 mm film and offers a speed range of 3¾ to 30 frames per second.

Heart of the device is the f/0.71 lens, about 30 times faster than a newspaper photographer's camera. An electronic triggering mechanism which turns the 100,000 to 130,000 volt x-rays on and off up to 30 times a second, in perfect synchronism with the motion pic-



ture camera, minimizing the x-ray dosage the patient receives.

Up to now, there have been only a few hand-built x-ray motion picture cameras in the country, and the availability of this equipment is expected to extend greatly clinical and research use of the technique.

While HOSPITALS endeavors to eliminate extravagant claims made for any product appearing in this section, the statements printed have been made by the manufacturer and are brought to your attention only to keep you informed of new developments in the field.

Folding table units (12B-3)

Manufacturer's Description: A folding table-bench unit now available can be wheeled through most doors when folded and locked vertically into its own all steel, caster equipped carrier. The unit consists of two tables and four benches, each 12 feet long, with a total seating capacity for 32 adults.

A 14-foot unit also is available, but this folds to seven feet and

will not clear through some door openings.

Plastic sprinkler systems (12B-4)

Manufacturer's Description: What is said to be one of the largest sprinkler systems in the West is being installed in the grounds of the Porterville (Calif.) State Hospital. Pipe is of tenite butyrate plastic. Lightness of weight, resistance to corrosion and ease of handling make its use economical. By means of butyrate plastic slip-sleeve

▶ To learn the names and addresses of manufacturers of products described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, 18 E. Division St., Chicago 10, Illinois.

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☐ Please send the name of the manufacturer to me.

_____ Signaling device (12B-1)
_____ X-ray motion pictures (12B-2)
_____ Folding table units (12B-3)
_____ Plastic sprinkler systems (12B-4)
_____ Mobile dish dispenser (12B-5)
_____ Monitor scope (12B-6)
_____ Patterned plastic dinnerware (12B-7)
_____ Waterproof diaper (12B-8)
_____ Radio paging system (12B-9)
_____ Remote control for television (12B-10)
_____ Electric stapling machine (12B-11)
_____ Colored adding machines (12B-12)
_____ Low-height mopping tank (12B-13)
_____ Oxygen-operated aspirator (12B-14)
_____ Nylon bedpan (12B-15)
_____ Hospital booklet rack (12B-16)
_____ Under-counter dishwasher (12B-17)
_____ Plastic padding for fracture casts (12B-18)
_____ Tube flanging device (12B-19)
_____ Glass tube inserting device (12B-20)
_____ Dual-temperature hot water bottle (12B-21)

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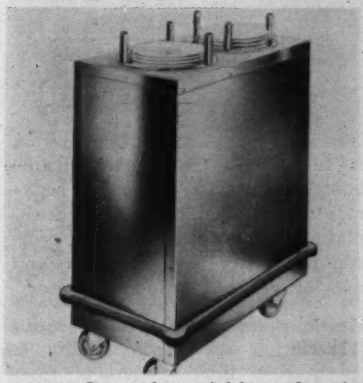
couplings and solvent cement, joints are made with a minimum of time and labor. Pipe sizes range from 3-inch for sprinkler lines to ¾-inch for the smallest feeder lines.

Mobile dish dispenser (12B-5)

Manufacturer's Description: A double-stack, mobile, self-leveling dispenser is mounted on all-swivel



casters. It can be quickly and easily wheeled to any service position. Wrap-around bumpers insure protection to dispenser and other equipment. Slide panel at bottom permits quick, easy cleaning.

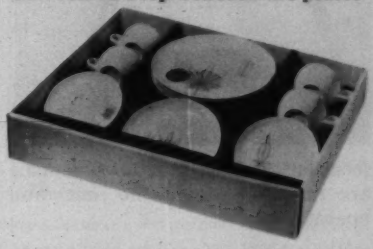
Monitor scope (12B-6)

Manufacturer's Description: A new concept of patient-nurse communications combines the advantages of both sound and sight. With this unit a nurse at her station can view patients as she converses with them. Camera units installed in the rooms transmit images to the monitor scope at her station.

Images of the rooms rotate at regular intervals on the monitor but can be halted and retained at will by the nurse.

Patterned plastic dinnerware (12B-7)

Manufacturer's Description: A newly-perfected process brings patterns to melmac dinnerware, heretofore available in solid tones only. Decorations are applied, heat-fixed and sealed deep beneath the plates'



surface to assure wear throughout life of the dish.

Waterproof diaper (12B-8)

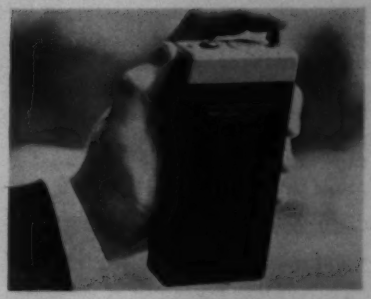
Manufacturer's Description: A diaper that is both waterproof and disposable helps prevent soiling of bedding and clothes. It is an item for use in the hospital and for sales appeal in the hospital gift shop. A soft nonwoven fabric lining and pad absorbs about two and one-half times more water than the average cloth diaper. The polyethylene outer coating provides hold-together strength, water and chemical resistance plus

featherweight and pliant texture. Ordinary safety pins fasten through reinforced edges which withstand body movement without ripping or tearing.

Radio paging system (12B-9)

Manufacturer's Description: Private, individual paging of physicians and key hospital personnel is now possible with a new pocket radio paging system. The receiver is only slightly larger than a pack of king-size cigarettes.

Up to several hundred persons can be paged individually, the additional channel capacity being added as needed. Audio volume of



the paged message, while entirely adequate for the paged person to hear, is low enough to provide privacy.

The operator at the sending station merely presses the proper selector button to activate a particular receiver alerting mechanism, then speaks into a desk microphone. No other receiver in the system hears either the alerting tone or the voice message which follows.

Remote control for television (12B-10)

Manufacturer's Description: Convenient patient control for television sets

in hospital rooms is made possible through a speaker unit placed on the patient's bed or within arm's reach. The speaker unit has all the dials of the television set, including on-off, volume, fine tuning, brightener and channel changer, allowing complete operation from as far away as 20 feet.

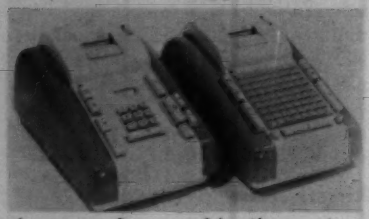
Electric stapling machine (12B-11)

Manufacturer's Description: Large-volume stapling may be done with

this automatic electric stapling machine. The stapling position on this unit is easily adjustable to a reach of 9¼″ This permits the hospital to staple booklets, multi-page folders and similar items at the center fold. The portable unit plugs into any 100-volt outlet.

Colored adding machines (12B-12)

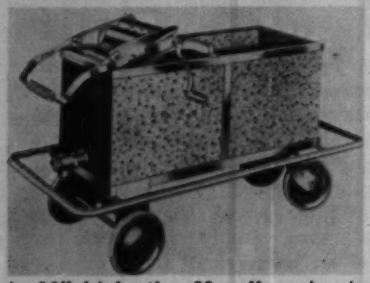
Manufacturer's Description: Adding machines in five pastel hues, designed to coördinate the machines with surroundings found in hospitals as well as general office decor and equipment. Interchangeable covers offer the buyer a variety in color choice and an opportunity to



change color combinations at a later date.

Low-height mopping tank (12B-13)

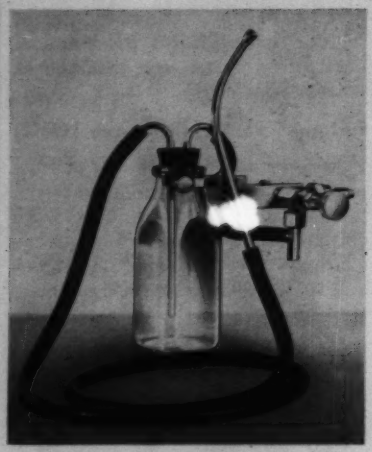
Manufacturer's Description: This two-compartment mopping tank has the features of other models; and for added convenience, it is 10″ to 12″ lower than others. Two sizes are available; the 30-gallon size



is 26″ high, the 60-gallon size is 31″ high. The main advantage is the minimized possiblity of damage to fixtures from swinging mops in low ceiling areas.

Oxygen-operated aspirator (12B-14)

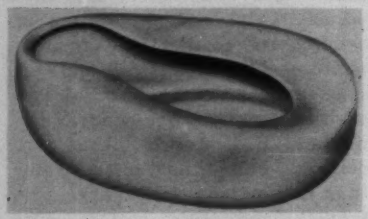
Manufacturer's Description: Aspirator can be inserted into an oxygen wall outlet. Designed primarily for hospitals that do not have a vacuum system installation. Also recommended for emergency service in patient rooms and other areas not equipped with a vacuum system. Lightweight unit can be moved readily from location to



location, and only a few seconds are required to put the unit into operation.

Nylon bedpan (12B-15)

Manufacturer's Description: New all-nylon bedpans and clinical utensils offer features not available with stainless steel and enamel-



ware. Clatter is reduced because of the sound-dampening quality of nylon. Nylon's natural warmth contributes also to patient comfort. The manufacturer guarantees the utensils to withstand autoclaving, boiling, detergents and conventional cold sterilizing agents as well as chemicals that corrode and stain. Available in grey and aqua colors in adult size only.

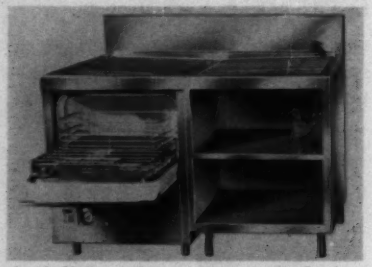
Hospital booklet rack (12B-16)

Manufacturer's Description: A hospital administrator has designed this bedside rack for hospital-prepared pamphlets and leaflets usually pro-

vided patients on admission. This rack was designed to make hospital literature always available and convenient to the patient. The rack is big enough to hold information booklets but not big enough for most magazines that would crowd out the literature. It may be fastened to the bedside table or to the wall by attached adhesive pads. This eliminates the need to bore holes or otherwise mar surfaces.

Under-counter dishwasher (12B-17)

Manufacturer's Description: This dishwashing unit provides a 48″ x 31″ working surface 34″ off the floor.



A full-length, corrugated drainboard has a spray rinse and separate drain. Washing is fully automatic. The complete washing cycle requires only 4½ minutes and uses only 4 2/3 gallons of water.

Plastic padding for fracture casts (12B-18)

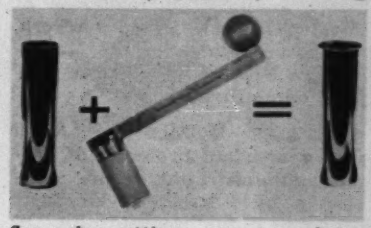
Manufacturer's Description: A porous plastic product that resembles foam rubber somewhat. A nontoxic, nonallergic material that may be washed, boiled and autoclaved. When plaster is applied, bond is established between the plastic

material and the cast, but the porosity of the material is such that the patient is free from cast irritations. The material is supplied in rolls of 2″, 3″, 4″, 6″ and 12″ widths, each of 72″ length.

Tube flanging device (12B-19)

Manufacturer's Description: A new, patented tool converts 1½″ scrap tubing into perfectly flanged tail pieces

in just 10 seconds. These pieces can then be used as new flanged tailpieces for sinks, flushometer valves and other plumbing fixtures. The tool is simple to operate. Just oil or grease the inside edge of tubing and clamp into vices. Turn handle, gradually forming



flange by putting pressure on handle knob.

Glass tube inserting device (12B-20)

Manufacturer's Description: Virtual elimination of lacerated fingers or hands while inserting glass tubing

into rubber stoppers, tubing and bulbs is made possible with this new inserting device. Three basic parts make up the device—the plunger, the adapter key and the inserter with flexible steel fingers for guiding the tube. Price of individual sets is $10 with discounts for lots of 3, 6 or 12.

Dual-temperature hot water bottle (12B-21)

Manufacturer's Description: The ribbing on one side of this hot water bottle makes possible dual temperatures from one bottle. The ribs permit cooling air to circulate when the bottle is placed rib-side down on the body. The ribbed side temperature is approximately 10 degrees cooler than the plain flat side.

product literature

Following is a listing of pamphlets and other types of literature on equipment and techniques. These are available to hospitals free of charge. The coupon provided below should be checked to indicate those titles being requested and whether the publisher's name should be sent to you or your name sent directly to the publisher to facilitate handling.

Clinical Memoranda on Economic Poisons—(12G-1) — This 54-page detailed report is based on continuing studies of the Public Health Service on poisons in public health and agriculture. A part of each memorandum is devoted to a description of the chemical nature, formulation and uses of the compound under consideration. The remainder is devoted to medical considerations, including mode of action, diagnosis and treatment handled under one or more headings.

The Application of the X-Ray Image Intensifier—(12G-2)—This technical review contains details on the medical aspects of the image intensifier as well as its industrial applications.

Sterilization Technique; A Survey of Standard Hospital Practice—(12G-3)—Detailed report of a survey which covered many facets of sterilization as conducted in hospitals today. Examples from study: (1) 87.8 per cent of the reporting hospitals use muslin for wrapping material for the surgical pack; (2) only 3.7 per cent of those reporting state that they do not use indicators.

Proper Treatment of Conductive Floors—(12G-4)—This folder provides detailed instructions for maintaining conductivity of floors in operating rooms and other areas where combustible anesthetic gases are used.

Nursery Equipment Brochure—(12G-5) — Itemizes equipment needed in the modern nursery, giving minimum requirements needed to meet public health standards.

Advantages of Machine Plastering—(12G-6)—Describes what machine plastering can do for the architect, the contractor and the owner of a building.

The Vacuslot Cleaning System—(12G-7)—Booklet describes new piped vacuum system for hospital cleaning. Installation charts and specification data are included.

Package Unit Steam Generators—(12G-8)—Detailed, well-illustrated booklet for small, medium or large plant installations.

▶ To learn the names and addresses of manufacturers of products described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, 18 E. Division St., Chicago 10, Illinois.

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_____12G-2 _____12G-4 _____12G-6 _____12G-8

NAME and TITLE _____

HOSPITAL _____

ADDRESS _____

(Please type or print in pencil)

personal news

• J. LEO ASH, administrative assistant of St. Mary's Hospital, Duluth, has been appointed administrator of St. Mary's Hospital, Leonardtown, Md. Mr. Ash has also served as treasurer of Taunton (Mass.) State Hospital, manager of credit and collections and director of public relations at St. Mary's Hospital in Duluth.

• CARDEN M. ASTIN, administrator of McRae (Ga.) Telfair County Hospital, has been appointed administrator of LaFollette (Tenn.) Community Hospital.

• ROBERT LEE BLACK has been appointed administrator of the Harlan (Ky.) Memorial Hospital, a unit of the United Mine Workers hospitals now under construction. Mr. Black had previously been selected as administrator of the Williamson (W. Va.) Memorial Medical Center.

WILLIAM B. ESSON, assistant administrator of Good Samaritan Hospital, Portland, has been appointed administrator of Williamson Memorial Medical Center. Mr. Esson is a graduate of the University of Chicago course in hospital administration.

CHARLES D. JENKINS JR., medical administrative officer with the Air Force Medical Service, has been appointed administrator of the McDowell (Ky.) Memorial Hospital. Mr. Jenkins is a graduate of the Medical College of Virginia course in hospital administration.

• CORA C. BLOSSOM, R.N., has been named administrator and superintendent of nurses of Appling General Hospital, Baxley, Ga. She is a graduate of the University of Georgia course in hospital administration.

• ENA M. BUNT, administrator of Ross (Calif.) General Hospital, has retired. DR. JOHN C. SIEMENS succeeds Miss Bunt as administrator of the hospital.

• CARDON C. CLEGG, superintendent of Brownsville (Pa.) General Hospital, has been appointed administrator of Grove City (Pa.) Hospital. He succeeds FRED W. SCHMID who is now administrator of Bradford (Pa.) Hospital. Mrs. JANEL L. SCHMIDT, assistant administrator of Brownsville General Hospital, has been appointed acting administrator.

• FRANCIS CUDA has been appointed administrator of Amsterdam (N.Y.) City Hospital. He had formerly served as director of nurses. Mr. Cuda is a graduate of the Catholic University of America program in hospital administration and succeeds J. AVERY PETERSON, who has returned to public relations work.

• JOHN H. DANIELS JR., has been appointed assistant administrator of North Shore Hospital, Manhasset, N.Y. He is a graduate of the University of Minnesota course in hospital administration. Mr. Daniels succeeds DONALD A. KINCADE who has been appointed administrator of Burlington (Wis.) Memorial Hospital.

MR. DANIELS

• WALTER W. ELLIS, administrator of Highlands (Ohio) Community Hospital, has been appointed administrator of the F. W. Black Community Hospital, Lewistown, Pa.

• RICHARD C. FOSTER has been appointed assistant administrator of Uniontown (Pa.) Hospital. Mr. Foster is a graduate of the University of Minnesota program in hospital administration.

• BRIG. GEN. JAMES O. GILLESPIE, former commanding officer of Letterman Army Hospital, San Francisco, is the new chief of the professional division in the office of the Surgeon General, Washington, D. C.

• MARY ANN GILSTER has been appointed assistant administrator of MacNeal Memorial Hospital, Berwyn, Ill. Miss Gilster, formerly assistant administrator of Copley Memorial Hospital, Aurora, Ill., is a graduate of the Northwestern University course in hospital administration.

• CHARLES GOULET has been named assistant professor of hospital administration at the University of Pittsburgh, Graduate School of Public Health.

Mr. Goulet has been assistant superintendent in charge of inpatient services at City Hospital, Cleveland, since 1953. He is a graduate of the University of Chicago program in hospital administration.

WILLIAM L. BRANSON succeeds Mr. Goulet at City Hospital. Mr. Branson is a graduate of the Washington University course in hospital administration. He was in charge of methods improvement at St. Luke's Hospital, Chicago, prior to this appointment.

• LEONARD W. HAMBLIN, administrator of Deaconess Hospital, Freeport, Ill., has been appointed administrator of Blessing Hospital, Quincy, Ill., succeeding MYRTLE MCAHREN who has retired.

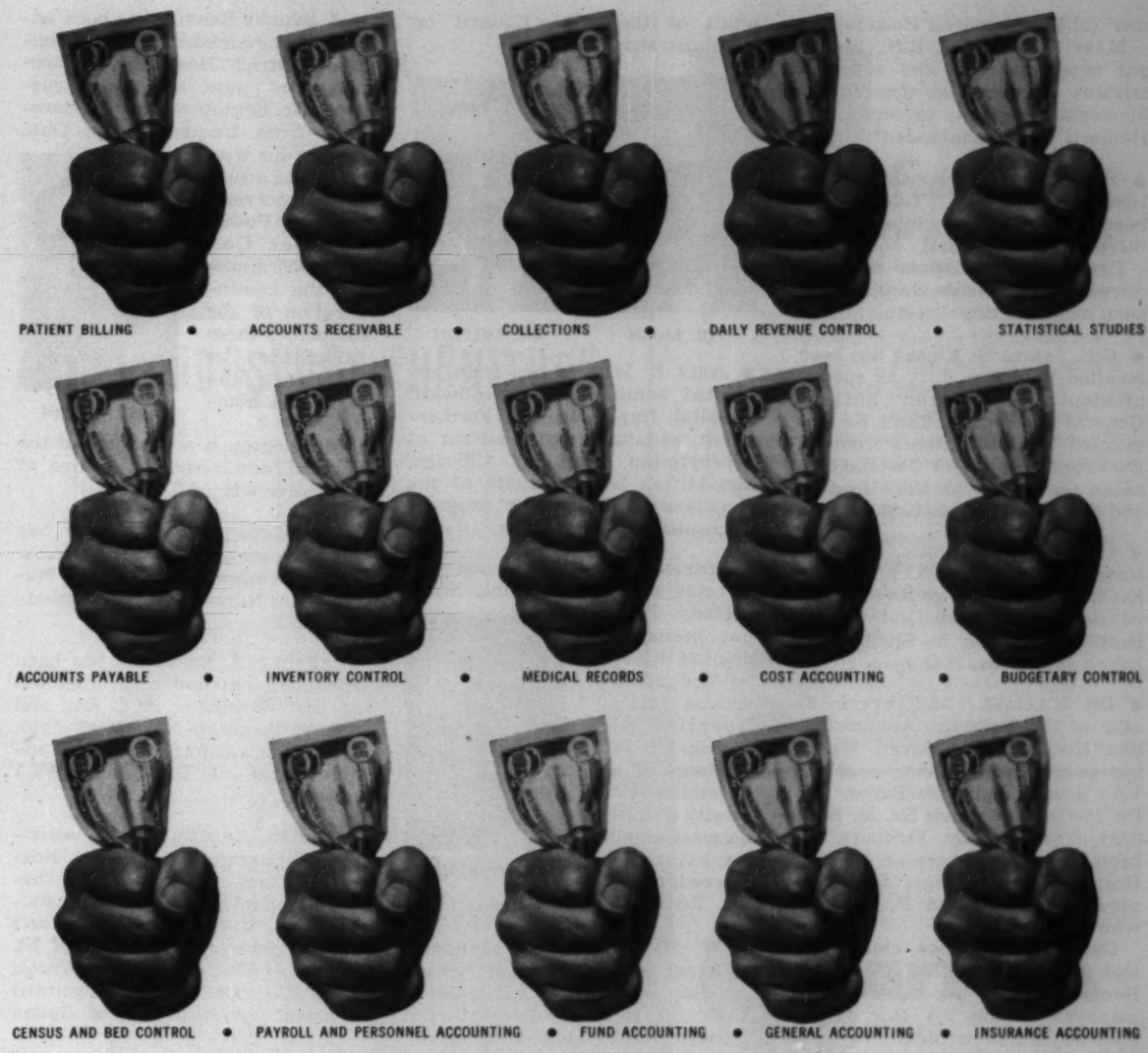
MR. HAMBLIN

MR. IAMS

• FRANKLIN P. IAMS, assistant director of Rhode Island Hospital, Providence, has been named administrator of University Hospital of New York University-Bellevue Medical Center, effective January 1. He succeeds DR. EDWARD M. BERNECKER who died last June.

Mr. Iams is a graduate of the University of Minnesota program in hospital administration.

• ALFRED M. HELBACH, superintendent of Community Memorial Hospital, Hamilton, N.Y., has been appointed administrator of Herki-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mer (N.Y.) Memorial Hospital.

MARY V. HINKLEY, R.N., assistant superintendent and superintendent of nurses at Community Memorial Hospital, succeeds Mr. Helbach as superintendent.

• PAUL W. KEMPE, director of Riverside Hospital, Toledo, has been appointed superintendent of Silver Cross Hospital, Joliet, Ill.

BERNHARDT A. ZEIHER, assistant director of Riverside Hospital, has been named acting director.

• COL. JAMES H. KIDDER has been recalled to active duty as special assistant to the Army Surgeon General for reserve affairs. He was granted leave of absence from St. Barnabas Hospital for Chronic Diseases, the New York City Hospital and the New York Medical College.

• GEORGE W. LAYCOCK, administrator of Conway (S.C.) Hospital has been appointed county administrator of the Cleveland County Hospitals, located in Shelby and Kings Mountain, N.C.

• DR. WILLIAM J. MCCARTY, manager of the Veterans Administration Hospital, Vancouver, Wash., has been named manager of the VA Hospital, Wilkes-Barre, Pa. Dr. McCarty succeeds DR. M. HERBERT FINEBERG. Dr. Fineberg has been named manager of the VA Hospital, East Orange, N.J., succeeding DR. ALFRED P. UPSHUR, who retired.

DR. IRVING ELDRIDGE, chief medical officer of the VA Center in Bonham, Tex., has been named manager of the VA Hospital at Fort Bayard, New Mex.

• PAUL MEYER has been named administrator of St. Mary's Hospital, Montreal. Prior to this appointment, Mr. Meyer conducted a survey of the Institute Clinica Physiotherapie Santa Rita, Isle of Pines, Cuba.

• CARL NUSBAUM, assistant director, Michael Reese Hospital, Chicago, has been appointed administrator of Rest Haven Hospital, Chicago. He is a graduate of the Northwestern University course in hospital administration.

• WILBUR C. MCLIN, administrator of Mound Park Hospital, St. Petersburg, Fla., has been appointed administrator of Community Hospital, Indianapolis, now under construction, effective February 1. Mr. McLin is a member of the Committee on Insurance for Hospitals of the AHA Council on Administrative Practice.

MR. McLIN

MR. MILTON

• JOHN E. MILTON has been appointed administrator of Edward Hospital, Naperville, Ill. Formerly an administrative assistant at Presbyterian Hospital, Chicago, Mr. Milton is a graduate of the Northwestern University program in hospital administration.

• JOSEPH J. POTORSKI, assistant director of Ellis Hospital, Schenectady, N. Y., has beeen appointed director of the North Adams (Mass.) Hospital. Mr. Potorski is a graduate of the Columbia University course in hospital administration and succeeds the late DR. ROBERT J. CARPENTER.

MR. POTORSKI

• W. H. PATTERSON was named assistant administrator of Arkansas Baptist Hospital, Little Rock. Prior to this appointment, Mr. Patterson was business manager of the hospital.

• DR. PERRY FRANKLIN PRATHER, Maryland's deputy director of health since 1942, has been appointed director, effective January 1. He will succeed DR. ROBERT H. RILEY.

• REAR ADMIRAL H. LAMONT PUGH, Medical Corps, USN, succeeds REAR ADMIRAL LESLIE O. STONE, as commanding officer of the National Naval Medical Center, Bethesda, Md.

Admiral Stone, who commanded the Center since June 30, 1955 is retiring after 37 years with the Navy Medical Corp. He is entering private practice at Tryon, N.C.

Admiral Pugh, former Surgeon General of the Navy, was inspector general of medical department activities prior to assuming his new command.

• J. SYDNEY RENTON has been appointed administrator of Sydenham District Hospital, Wallaceburg, Ont., now under construction. Mr. Renton went to Wallaceburg from Iroquois Falls, Ont., where he was hospital business supervisor at Abitibi Power & Paper Co., Ltd., coördinating the administration of the company's three hospitals in Northern Ontario and Manitoba.

MR. RENTON

Mr. Renton is a graduate of the hospital administration course at the University of Toronto.

• DR. STUART M. SESSOMS has been appointed assistant director of the Clinical Center of the National Institutes of Health, Bethesda, Md.

• ARTHUR E. SHADE III has been appointed assistant superintendent of the Manhattan Eye, Ear and Throat Hospital, New York City. Mr. Shade was formerly acting administrator at Pottstown (Pa.) Hospital.

• SISTER ANGELA CLARE, assistant administrator of Spohn Hospital, Corpus Christi, Tex., has been appointed administrator, succeeding SISTER MARY VINCENT who is now administrator of St. Joseph's Hospital, Fort Worth. JOHN L. RYAN has been appointed assistant administrator of Spohn

SR. ANGELA CLARE

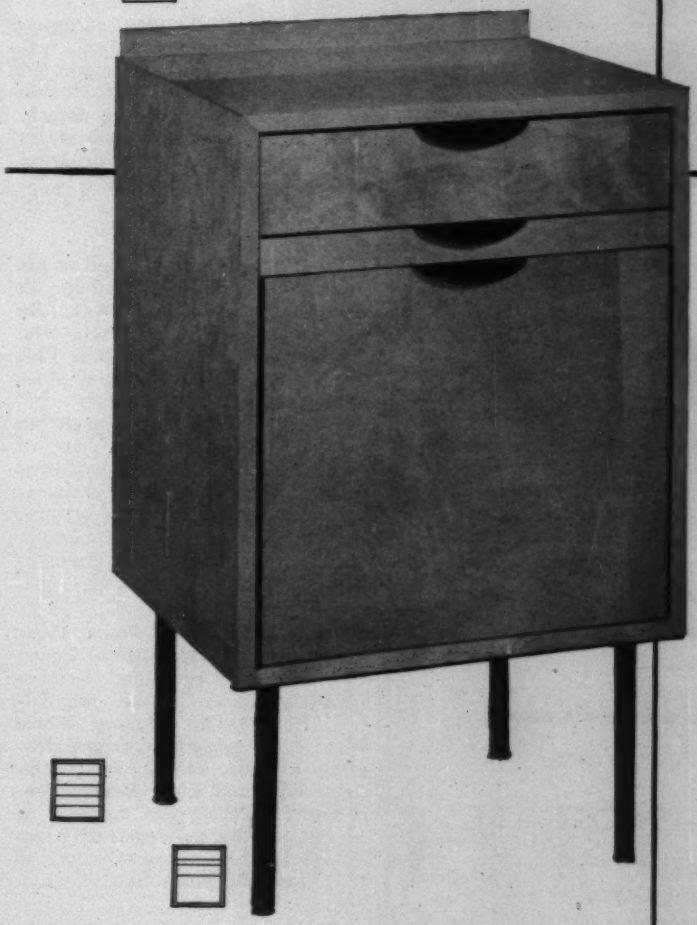
MR. RYAN

Hospital. He is a graduate of the St. Louis University program in hospital administration.

• SISTER MARY BERTHA, superior of St. Joseph's Hospital, Lexington, Ky., has been appointed superior-director of St. Joseph Infirmary, Louisville. Sister Mary Bertha has also served as administrator of Sts. Mary and Elizabeth Hospital,

New...

KALEIDOSCOPE FURNITURE



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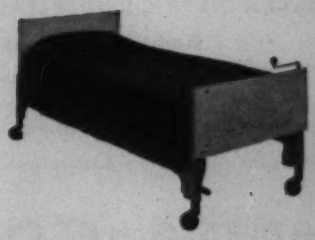

TYPICAL of the KALEIDOSCOPE grouping is this **CARROM - 2 - HEIGHT** Bed . . . electric or manual. The grouping also includes easy chairs, side chairs, overbed tables and flower tables.

Our Lady of Peace Hospital, Louisville, and as assistant administrator of Holy Family Hospital, Ensley, Ala.

SISTER MARY ANTONELLA, assistant administrator of St. Joseph Infirmary, has been named administrator. Prior to going to Louisville, she was administrator of Georgetown University Hospital, Washington, D. C.

• SISTER M. GERMAINE, H.H.M., has been appointed administrator of St. Joseph's Riverside Hospital, Warren, Ohio, succeeding SISTER M. BAPTISTA, H.H.M., who has been named assistant administrator at St. Elizabeth's Hospital, Youngstown, Ohio.

• SISTER M. TERESITA HARTNETT has been named administrator of St. Dominic-Jackson Memorial Hospital, Jackson, Miss. She has served in several capacities at the hospital, including assistant administrator and surgical supervisor.

• SISTER TIMOTHY MARIE FLAHERTY, has been appointed administrator of Queen of Angels Hospital, Los Angeles. She is a graduate of the St. Louis University course in hospital administration.

• DONALD F. SMITH has been named superintendent of Minneapolis General Hospital. He was formerly an assistant to the director of the University of Minnesota Hospitals in Minneapolis.

• ROGER R. STARN has been appointed assistant administrator of Good Samaritan Hospital, Portland. He is a graduate of the University of Minnesota program in hospital administration.

MR. STARN

Mr. Starn served a year in the Navy and two years in the Army Medical Service Corp.

• WILLIAM W. TURNER, administrator of Memorial Hospital, Logansport, Ind., has been appointed assistant administrator of Seaside Memorial Hospital, Long Beach, Calif. Mr. Turner is a graduate of the University of Chicago program in hospital administration.

Congratulations!

ARNOT-OGDEN MEMORIAL HOSPITAL, Elmira, New York
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WEBSTER DISTRICT HOSPITAL, Webster, Massachusetts
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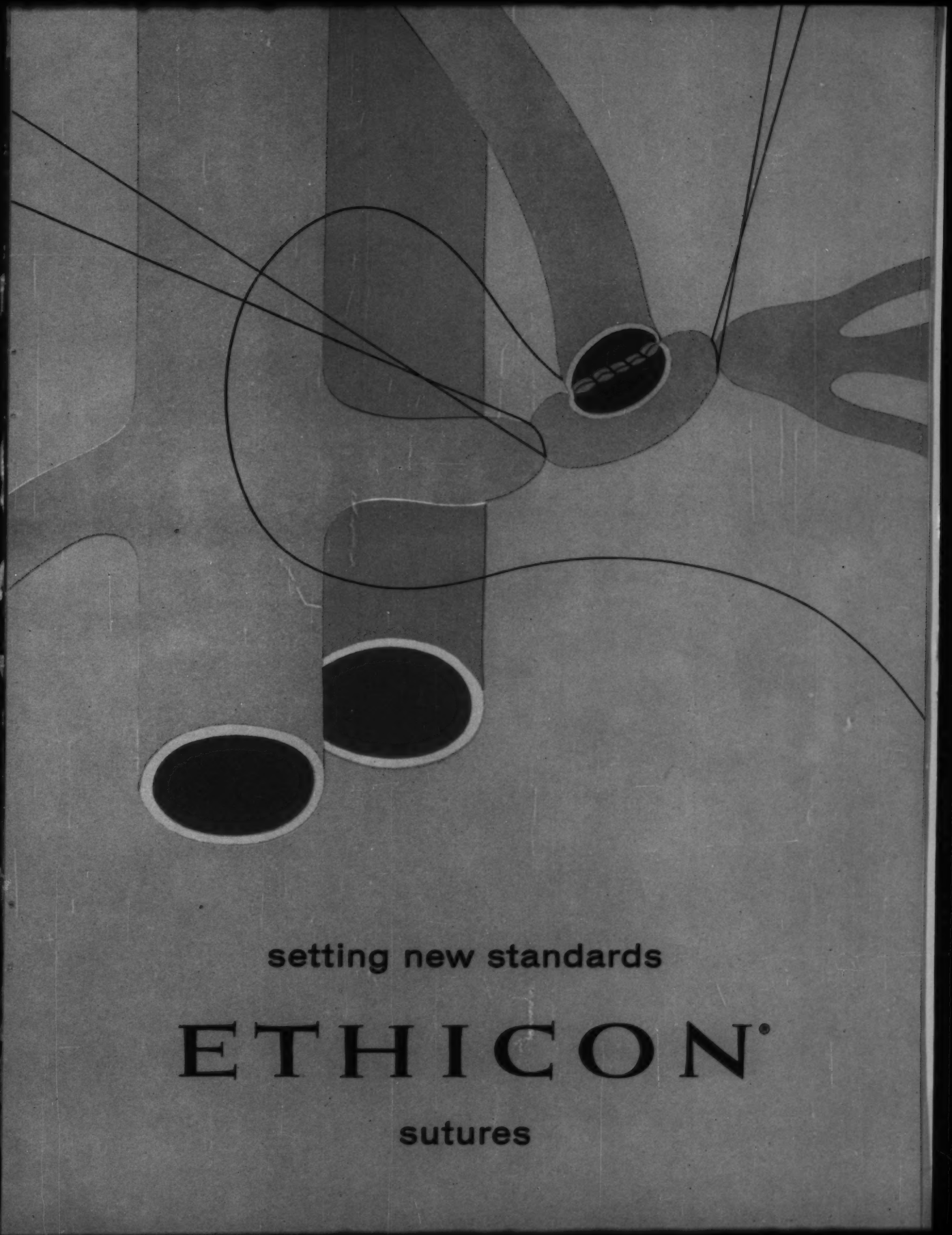
Deaths

• GEORGE A. BALL, 92, died at his home in Muncie, Ind., October 22 after an illness of three weeks. He was the last of five brothers who invented the mason jar. The Ball brothers built Ball Memorial Hospital for the city of Muncie.

In 1948, Mr. Ball was made an honorary member of the AHA at its 50th anniversary and was presented a citation for his outstanding contribution to public service. He was also an honorary member of the Indiana Hospital Association.

• LT. COMMANDER JOHN PAUL THOMAS BENNETT, Hospital Corps, U.S. Navy, retired, died October 15 at the Naval Hospital, San Diego. He was 63. During World War II, he served in Naval Hospitals at Mare Island, San Diego, Oceanside, and Long Beach. Preceding his retirement in 1947, he served as the administrative assistant to the executive officer at the Naval Hospital, San Diego.

• DR. WILLIAM E. EATON, 73, hospital surveyor for the American Medical Association's Council on Medical Education and Hospitals,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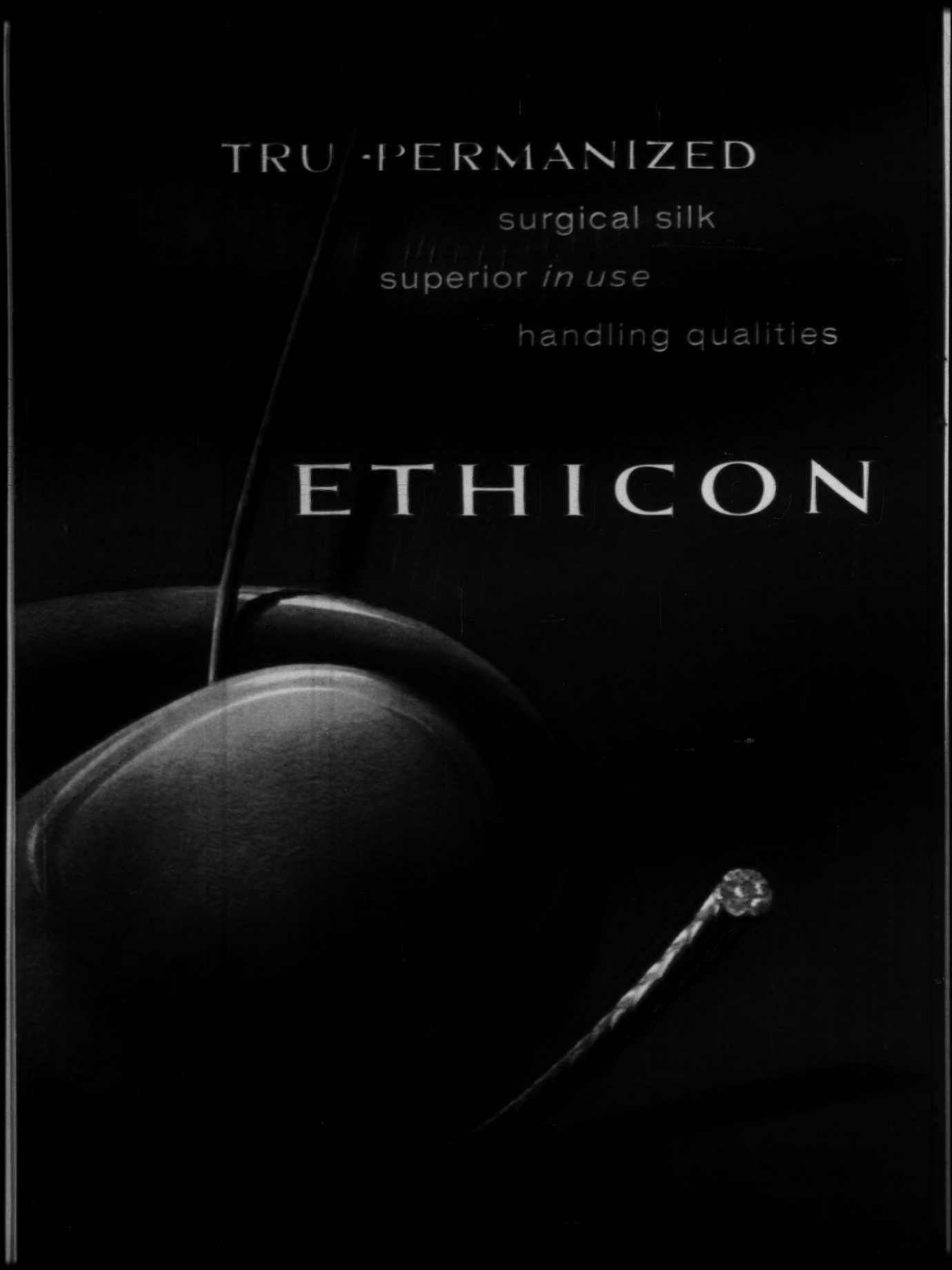
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from December 1954 to June 1955, died in October. He was formerly a surveyor for the American College of Surgeons.

● DR. ROBERT H. HALSEY, a founder of the American and New York Heart Associations, died September 15 at the age of 82. In 1922, Dr. Halsey presided over the St. Louis meeting of physicians and health workers which led to the formation of the American Heart Association, and later he became its first secretary. He served as its president in 1932. In 1950, Dr. Halsey received one of its first Gold Heart Awards for outstanding contributions to the fight against heart disease.

● DR. JULIUS H. HESS, 79, internationally known Chicago pediatrician noted for his pioneering efforts in saving lives of premature infants, died November 2 in Los Angeles. He was senior attending physician and past staff chairman at Michael Reese Hospital, where he introduced the Hess baby incubator and founded the premature birth station.

● DR. EUGENE BENNETT PIERCE, a former superintendent of the Molly Stark Hospital, Canton, Ohio and the Michigan State Sanatorium, Howell, Mich., died August 29 in Akron at the age of 79.

● EDGAR E. RAND, 50, president of the International Shoe Company and a trustee of Barnes Hospital, St. Louis, died of a heart attack October 26. He was also a trustee of Vanderbilt University, Nashville, and on the board of directors of the St. Louis Community Chest.

● DR. SIGSBEE RAYMOND SELJESKOG, 55, a former superintendent of the Elizabeth Kenny Institute, Minneapolis and staff member of the Lutheran Deaconess Home and Hospital, died August 15.

● SISTER M. AUXENTIA, 66, Mother Superior and administrator of St. Peter's Hospital, Brooklyn, died October 19 at the hospital after a long illness. Sister Auxentia, a registered nurse, went to St. Peter's Hospital in 1949. She was active in the professional and structural rehabilitation of the hospital.

● SISTER MARY ESTHER, administrator of St. Peter's Hospital, Albany, N.Y., for the past 21 years, died October 7 after an illness of two months.

● DR. JAMES F. STEVENSON, 61, past-president of the Oklahoma State Medical Association and trustee of the Oklahoma Blue Shield Plan died recently after a lengthy illness. Dr. Stevenson was one of the original doctors in the state who was instrumental in organizing the Blue Cross and Blue Shield Plans in Oklahoma.

● JOSEPHINE E. THURLOW, R. N., died September 25. Miss Thurlow served 37 years as superintendent of hospitals in Massachusetts, New York, Michigan and Ohio. She had also served 21 years on the Board of Nurse Examiners in Massachusetts. Miss Thurlow had been retired for the past nine years.

● CHARLES A. VOSS, 53, general counsel and a director of the United Medical Service, New York City, died October 6. While conducting a general law practice in White Plains, Mr. Voss helped draft legislation for the United Medical Service's Blue Shield Plan and for other voluntary prepaid medical insurance programs.

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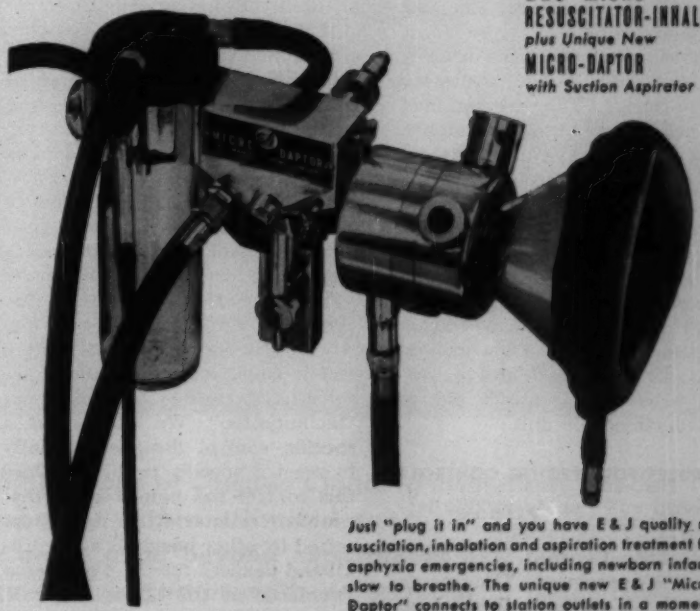

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laundry-housekeeping

production and cost control *in the laundry*

JOHN G. STEINLE

CONTROLS ARE the methods used by management, through the leverage of administrative action, to establish qualitative production and cost standards. They may be grouped under two broad headings—(1) general controls and (2) specific controls.

General controls are those usually applied to the entire operation or organization. They are designed principally to maintain a balance among units of the organization. Usually, these controls fix units of cost so that problems among departments can be identified. The two principal general controls are budgeting and cost accounting.

Specific controls are designed to meet the problems of a certain department or unit. They include norms for personnel and equipment productivity applicable to the department or unit.

RULES FOR SPECIFIC CONTROLS

Several rules apply to this latter group. These include:

1. *Specific Controls Must Be a Tool of Management.* They never should be an end unto themselves. Unnecessarily burdensome and costly controls are as impractical and undesirable as inadequate, ineffectual controls. In hospital laundries, for example, the methods of inventory control often are more costly than any loss which probably would result if the controls did not exist.

2. *Specific Controls Must Be As Simple As Possible.* They should be understood and accepted by everyone concerned with their application. From time to time, we still find places where complex and difficult controls have been established. We find that these controls receive the "old Army game" treatment—that is, top management has established the controls while operating personnel constantly plan new ways to circumvent them. Controls cannot and should not be used as a method of disciplining personnel.

3. *Specific Controls Must Be Designed to Fit the Function They Are to Perform.* Hospitals often suffer from a disease sometimes referred to, rather facetiously, as "techniquitis." We often find a specific control designed initially to meet a specific problem. Once this control has helped solve that problem satisfactorily, it may be seized by other hospitals as a cure-all and panacea for their problems. Problems in the other hospitals, however, may be completely unrelated to the one for which the control was designed.

One of the principal problems in laundries is the maintenance of an even or level work output. Often, the workload is heavy during certain periods and light during others. Monday usually is heaviest since soiled linen has accumulated over the weekend, yet pressure often is placed on setting staffing patterns according to requirements of the peak-load period instead of adjusting to fit actual requirements. Too often, we staff for the "crisis" instead of the normal workload.

If we are to staff properly, therefore, it is essential that we determine our "normal requirements." The first step in controlling production is to analyze the workload. This should be done by type and by time period. In the laundry, workload can be classified by weight according to the washing process required (by soiled, medium soiled or heavily soiled) and by the finishing process required (flatwork ironed, tumbled, press-finished).

Excessive variations in day-to-day workloads often can be reduced once the problem has been identified. We have found institutions in which items such as dresser scarfs, which can be changed and washed at any time during the week, are processed as a matter of routine on Monday mornings, when the uncontrollable workload of the laundry is at its heaviest. Elective items—those which may be considered the controllable workload—can be scheduled and laundered when the workload is lightest. The dresser scarfs mentioned above could be processed Thursday or Friday.

Before a sound system of production control can be established, based either on norms of work output or cost per procedure, all problems in the work environment should be eliminated or reduced. Work environment problems in-

Mr. Steinle is principal associate, Cresap, McCormick and Paget, management consultants, New York City.

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clude (1) conditions that reduce effectiveness of employee performance, such as overcrowding, insufficient workspace, unnecessary heat, excessive moisture and distracting noises; (2) inadequate or poorly located equipment; (3) repetitive and unnecessary procedures or separate procedures that could be combined, and (4) improper scheduling.

IMPROVING CONTROLS

Among ways to improve conditions as noted above and consequently increase production are:

1. *Combining Procedures.* An example is the linen control system of a laundry which required the counting of dirty linens. In a second and separate process, the dirty linen was separated by classification of soil. The procedures could be combined so that classification was made while the linens were being counted. Also, in the counting process, torn or threadbare linens could be separated from strong, new linens.

2. *Using Proper Size Equipment.* Were inadequately sized equipment to be used in conveying pieces from the extractor to the flatwork ironer, tumblers and presses, for example, this equipment would cause slowdowns and congestion. Equipment needs should be determined by the workload. In this case, castered feed horses, castered tables, spreaders, castered feed trucks or castered hampers might be needed.

3. *Setting Proper Work Schedules.* Work schedules often are poorly planned. We recently found one institution where all personnel come to work at the same time and leave at the same time. This practice ignores normal completion of part of the wash cycle by certain personnel before others can do their work.

4. *Using Mechanical Devices.* Adequate equipment often can reduce the manpower requirements. The installation of automatic folding equipment in large laundries, for example, can reduce costs substantially.

5. *Providing Proper Working Conditions.* Poor working conditions lower morale, increase turnover and generally reduce production. Such physical considerations as pitched floors for carrying off water, are very important, as are adequate lighting and proper ventilation.

After environmental problems have been reduced or solved, production norms should be developed in the laundry under controlled conditions. The norms or standards so developed then will apply directly to the specific institution concerned. Often, we find that norms used in one institution are unrealistic if applied to another. This may be attributable to such things as size of the operation, type of workload or physical design of the laundry.

DEVELOPING PRODUCTION CONTROLS

Some hospital laundries fail to keep the most fundamental and basic records for purposes of production control. They neither count nor weigh their workload in order to provide production information. Costs of the various operations are not determined so that performance can be analyzed or measured. Consequently, it is not possible to compare costs of the various laundry operations with past performances, nor can comparisons be made with developed norms.

In many hospital laundry plants, no records of hourly, daily or weekly operator productivity are maintained, or such records are inadequate. Consequently, supervision can only be achieved by observation. This method is poor, uncertain and often costly.

In some hospitals, certain general norms have been established. These norms, however, either are too broad to provide realistic yardsticks for measuring performances of individual operators, or they have not been kept current. It is possible that comparisons of present production are being made with an old criterion which was established when conditions were somewhat different. We have found that standards based upon old performance records usually are 20 to 30 per cent below the possible and reasonable normal levels of current production.

In order to establish adequate controls over the actual processing of laundry, the following steps should be taken in addition to determining and classifying workloads:

1. *Work Flow Should Be Studied and Simplified Where Possible.* Equipment should be installed to meet load requirements. Procedures should be analyzed and adjusted where necessary. Problems involving working conditions and personnel should be identified and solved.

2. *After Environment Problems Have Been Eliminated or Reduced, Norms Should Be Established.* An expected hourly output should be established for each employee and for each piece of equipment. When production rates fall below established norms, an immediate investigation should be made. Production norms should not be used to compel personnel to maintain an unreasonable schedule; they should define the problem, however, identify the focal point of a slowup, indicate an unusual change, and establish inadequacies in manpower and equipment.

In every plant, there are certain operations that do not lend themselves to the application of production standards. It is unrealistic to try to force standards on these activities.

3. *Work Flow Should Be Scheduled So That Quick Checking Will Immediately Disclose a Slowdown.* Variations in hourly production sometimes indicate that the flow of work needs revision, or that productivity of the equipment is not in balance with workload requirements.

DEVELOPING PRODUCTION NORMS

To establish production norms for each operation in the laundry (those illustrated in the accompanying table, opposite page, were determined recently for one hospital laundry), the following are essential:

(1) A detailed analysis should be made of functions of each employee.

(2) Tasks and activities should be fully explained—for example, loading of the washer to a certain level with a specified type of wash.

(3) Each task should be broken down into elements, which may be defined as motion or movements which constitute the smallest single unit of work—for example, setting the controls of a washer. Dividing tasks into elements, each of which has a specific "break

norms for selected laundry operations

OPERATION	TIME PER UNIT
Classify according to soil	9 min. per 100 lbs.
Wash and extract	12 min. per 100 lbs.
Tumble towels	86 min. per 100 lbs.
Shake out sheets	55 min. per 100 pieces
Flatwork iron sheets (8-roll)	55 min. per 100 pieces
Press doctors' jackets (white duck)	1.8 min. per piece
Press pants (white duck)	2 min. per piece
Press gowns (operating room)	2 min. per piece
Press fold doctors' jackets (white duck)	.8 min. per piece
Press fold pants (white duck)	.7 min. per piece
Press fold gowns (operating room)	1.7 min. per piece

point," allows the standard for the task to be easily and quickly adjusted if any of the elements are changed.

(4) Over a period of time, the elements of each operation and the actual time required for each performance should be determined. The time needed for an adequate sample will depend to a large degree on the complexity of the operation and the amount of variation in the performance. Each element of the task should be recorded on a time study sheet and the time required for its performance determined with a stop watch.

(5) Since each person has his own rate of speed, or "pace," adjustments must be made. If many persons are performing the same element, a mean or average time of performance can be obtained. If there is only one person or several performing the same task, an arbitrary adjustment for normal performance must be made.

(6) When a "normal time" has been computed for each element or component of a task or operation, the time for the components should be totaled. The result will be a norm for the total operation. By doing this, defects in the operation can be quickly diagnosed and the trouble localized, and norms can be easily adjusted when there is a change in technique of the operation.

(7) All time loss inherent in the job should be determined. This includes periodic waiting for delivery of work. Allowances should also be made for personnel fatigue.

(8) Thus the number of operations that normally can be expected from each operator per hour can finally be computed.

Norms also may be used for other purposes than evaluating performance and identifying problems. Work output can be used as the basis for compensating the employee for the work he performs. This is commonly referred to as "incentive compensation." There are three principal methods of computing this compensation:

Piece Basis. The employee is paid a certain amount for each piece processed. This system is particularly applicable to such activities as the pressing operations. Obviously, a reasonable compensation rate by type of item processed cannot be established without reasonable standards or norms based on the actual working conditions.

Bedeau or Modified Bedeau System. This is sometimes referred to as the production line incentive plan. The total department or a major unit, such as a complete processing line, is compensated according to the total output. In the laundry, for example, the rates of compensation for various personnel can be adjusted to the daily production. This system is generally satisfactory only where a limited number of different kinds of items are processed; otherwise, it is difficult to administer the plan, since too many variables affect total production.

Bonus for Work Above Norm. In this system, an expected daily production level is established. Workers are compensated for performance above that level.

All three of these methods give the employee an opportunity to share in the fruits of his labor and his improved performance. An actual example of the benefits which may result from using the incentive system in press operations is found in one hospital laundry where the number of press operators was reduced 60 per cent, the individual income of those remaining increased 35 per cent and the net savings in the operation increased approximately 45 per cent. Obviously, with a reduction in the number of operators and presses there was a substantial savings in space.

OTHER COST CONTROLS

While production norms and work standards are probably the most important methods of production and cost control in the laundry, there are many other areas which require attention in controlling cost.

Often we find that organization of the laundry is such that it is difficult, if not impossible, to exercise administrative controls. Before specific controls can be established and used effectively, the administrative environment or organization must be such that supervision can be effectively exercised. We may have a lack of coördination between the sewing room, the linen room and the laundry. This is not uncommon, yet we have found, generally, that the laundry must be responsible for administration of these units, or that the same person must be administratively responsible for all three.

LINEN USAGE RECORD

While hospitals often fail to maintain records of production and production costs, they fail even more often to maintain linen usage records.

Physical inventories of all linens often are incomplete, of little relative value. Often, no adequate records are kept of linens issued for use, of worn linens withdrawn from use or those used for manufacture of small specialty items. We sometimes find that the linens have been dated when purchased. This has little value, because they will go into the supply room for a long time before being issued. We find, generally, that the more effective method of determining the life of various linens is by sample studies instead of an attempt to study the life of all linens.

In a large linen room, where a number of seamstresses are em-

ployed, no attempt is generally made to establish individual production records of either the seamstresses or the materials used. Yet seamstresses can be paid very effectively on a piece basis.

All items manufactured in the sewing room should be priced. All costs items should be included in the estimate for each item manufactured. These costs should be periodically compared with the current market. Similarly, those items which could be manufactured, but are not, should be made in small quantities and priced on a pilot basis, with necessary adjustments to achieve a realistic cost estimate. Comparisons then should be made with the market prices. This permits scientific determination of the feasibility of expanding or contracting the manufacture of linen items.

WASHING FORMULAS

Washing formulas often are excessive and uncontrolled. We have found instances where hospital laundries use the same washing formula for part or full loads, for soiled, medium soiled and heavily soiled items including diapers. The same number of sudsings and rinses are used regardless of the type of load. One hospital, for example, used four unnecessary rinses for each operation. Since in this laundry each rinse required 150 gallons of water, the total waste ran as high as 20,000 gallons per day.

We have often found that the dirty linen load placed in washers is not measured; consequently, the washman does not know the amount of detergent to add to maintain his proper formula. We also have found that where a 12" water level is used for the sour, this is followed by a 12" cold rinse. The sour operation might as well be eliminated altogether, since the sour is rinsed out and no value obtained from it.

Lack of washing controls often results in excess costs, as for example where all soiled linens are washed together, including diapers. The washing formula must provide for the heaviest classification. This means extra sudsing. The long suds time not only wastes manpower, water and materials, but also causes unnecessary wear and tear on the linens. In all cases where practicable, classification should be made according to washing and handling requirements of the linens. Adequate controls can be established to assure use of appropriate quantities and formulas.

In order to maintain proper records, inventory records of supplies should be established and maintained. Meters should be installed for measuring steam, water and electricity consumed by the laundry.

STANDARD PRACTICES

Often there is no schedule of procedures by item; diapers, pajamas and trousers are run through the flatwork ironer contrary to recommended practice. Laboratory coats, after being pressed, are hand-finished to eliminate wrinkles, and sleeves are puffed by use of hand irons. A schedule should be drawn up for each item, listing the appropriate method and procedure for processing. In this way, consistency will be achieved and unnecessary finishing operations eliminated.

Standard practices and controls often can serve a number of purposes. Internal operations of the laundry can be improved, for example, through simple methods which also improve sanitation. Hampers for handling clean linens can be stenciled "clean linen only," eliminating the unsanitary practice of using the same hamper for soiled and clean linens.

By numbering each hamper, better controls can be instituted in the washing procedure. The washing then can be distributed through the week by dividing hampers into five groups each stenciled with the day its contents should be laundered.

Improvements in preventive maintenance generally result from a fixed schedule and a check list which indicates the checking procedure and the day of the month when each item is to be inspected.

The laundry can help in maintaining the controls of other units of the hospital. At least one laundry, for example, has developed a plan with the chief of surgery by which all surgical instruments recovered in the laundry are listed, showing date of recovery and the identifying mark of the operating room to which it belongs. This helps the chief of surgery evaluate the care exercised by operating room personnel.

SUMMARY

Major savings can be realized through improved control of linen and laundry operations. Controls must be designed to meet the specific problem. They must be simple and understood by all personnel of each unit involved. They must have the acceptance and coöperation of these personnel. Controls must be designed to provide the best return for the minimum expenditure of funds, since unnecessarily costly and complex controls can be as undesirable as ineffective or insufficient controls. ■

Notes and Comment

An attendant, observing that the 450-pound-capacity extractor was vibrating excessively, walked to the control button to shut down the machine. Before he had a chance to activate the button, the heavy canvas cover flew out of the machine, knocking the attendant down after spinning him around several times. He was badly shaken; but, by luck, he escaped serious injury.

The cover, used to prevent laundry from rising above the level of the rotor, apparently freed itself from under the lip of the stationary outside shell. Centrifugal force pushed it out of the machine, through the edge of the closed lid.

According to the manufacturer, this is a very rare accident. Controls are available which will automatically shut off the extractor in the event it develops excessive vibrations due to dynamic unbalancing. This machine did not have such a control. However, the following precautions should be taken:

1. Balance the loaded rotor statically.

2. Fit the cover into place carefully.

3. Observe the operation closely, particularly until it reaches full speed. Be aware that a rotor which balances before it is spun will not necessarily stay in balance while it is being spun.—*Safety-Script*, Mississippi Hospital Association, Aug. 8, 1955. ■

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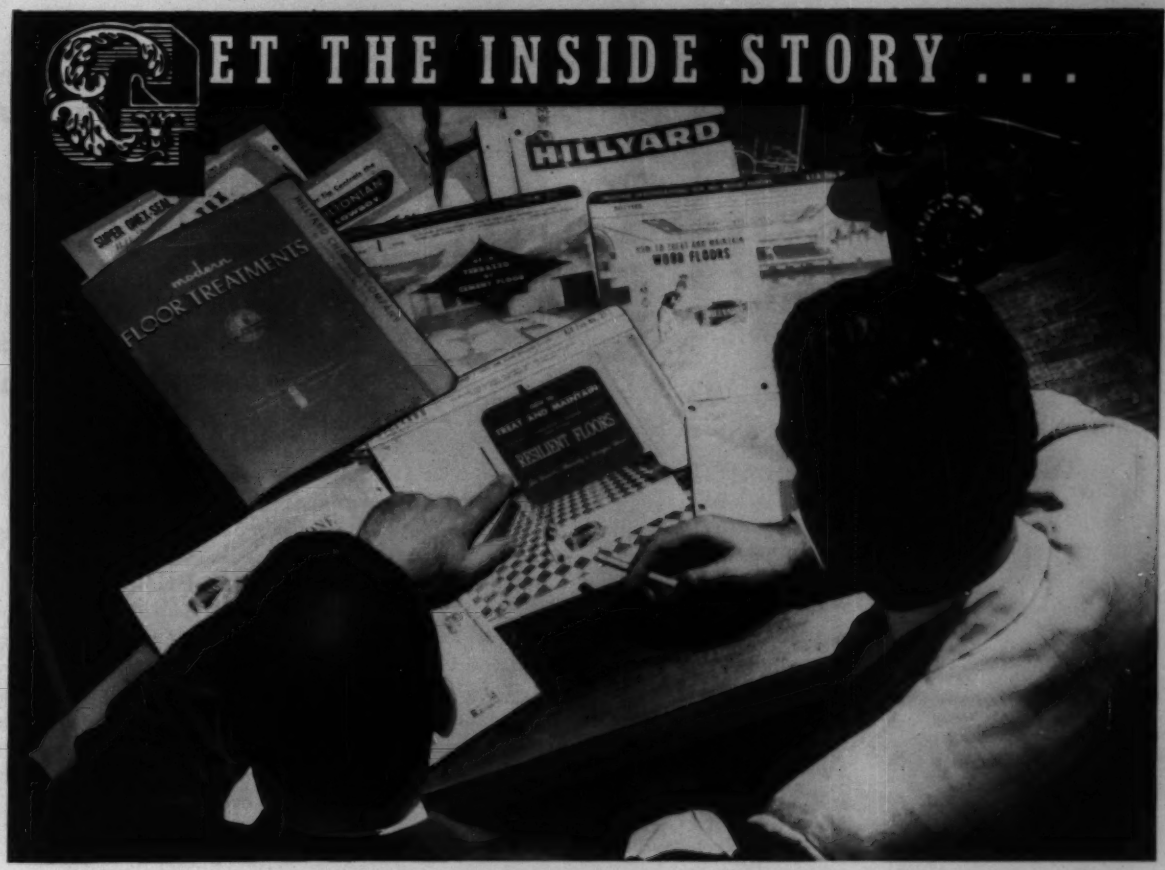

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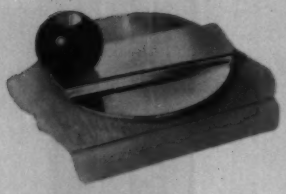
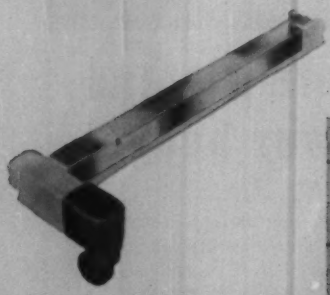


Crank handle is on top of table for ease of operation, yet is designed so as not to snag attendant's clothing or the bedding.



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OFFICIAL NOTES

The Board of Trustees has approved certain principles to guide the development of legislation for the health needs of the aged, recipients of public assistance and the dependents of servicemen. The House of Delegates subsequently approved these statements at its Atlantic City meetings, Sept. 19-21, 1955.

The statement concerning the recipients of public assistance is published below. The other statements will be published in subsequent issues of HOSPITALS.

1. The recipients of health services shall be defined as those persons who are on the public assistance rolls in each individual state.
2. The program shall avoid any direct payment by the federal government to the individual recipient or to any institution or individual providing health services.
3. The grant of federal funds shall be to a single state agency.
4. The administration of funds may be handled by the state agency in one of the following three ways:

a) The state agency may arrange for coverage of the recipients of health services through the mechanism of nonprofit voluntary health insurance organizations.

b) The state agency may arrange for nonprofit health insurance organizations to act as administrative agencies to be reimbursed for the cost of health services rendered and agreed costs of administration.

c) If, in the judgment of the state agency, administration of the program of health services required by persons on public assistance rolls cannot be provided under paragraphs a) or b) above, then the state agency may arrange for direct payment to institutions and individuals rendering health services. This might be handled through the pooled fund method.

5. Any grant-in-aid program with federal funds being matched by the states should, to the extent

(Continued on page 150)

AHA Breaks Ground

AHA PRESIDENT Ray E. Brown turns first shovel of earth at ground breaking ceremonies for Association Headquarters and Center for Hospital Affairs, Lake Shore dr. at Pearson st., Chicago. Left to right are Northwestern University President J. Roscoe Miller; Mayor Richard J. Daley of Chicago; Rt. Rev. Msgr. John W. Barrett, director of Catholic Hospitals, Archdiocese of Chicago, and Dr. Edwin L. Crosby, AHA director.

More than 200 persons were on hand November 9 for ground breaking ceremonies for the American Hospital Association Headquarters and Center for Hospital Affairs, Chicago.

Participants included AHA President Ray E. Brown; Mayor Richard J. Daley of Chicago; Dr. J. Roscoe Miller, president of Northwestern University, and Dr. Herman N. Bundesen, president of Chicago's Board of Health.

Honor of scooping the first shovelful of earth went to Mr. Brown, who performed for a host of photographers and a permanent color film record of the event for the Association archives. He described the ceremonies as "a historic moment in the growth of the American Hospital Association, and for the hospitals of the United States and Canada." He added, "It is, we trust, even more significant for the people of our nations to whose welfare we are dedicated."

Mr. Brown said, "Hospitals and the American Hospital Association must be ready not only to accept the offerings of the world of science, but must also contribute to the world of science . . . This means more than simply improving the hospital service already available. It means that we must broaden our horizon of service."

The AHA president cited smaller hospitals as "a foundation stone of the nation's health." The American Hospital Association, he said, has "already taken steps to give them more help," and he pledged further aid.

Mayor Daley, who termed the chill November breeze a justification of Chicago's "Windy City" reputation, said that construction of the Headquarters and Hospital Affairs Center would "add to Chicago's already great lustre as a health center."

He told assembled hospital leaders and civic officials that "the American Hospital Association has

MR. BROWN awaits turn as Dr. Miller signs lease for building site on behalf of Northwestern University. Standing by (l. to r.) are Dr. H. M. Coon, AHA trustee and superintendent of University Hospitals, Madison, Wis.; Dr. Frank R. Bradley, AHA's immediate past president and director of Barnes Hospital, St. Louis; Joseph G. Norby of Milwaukee, member of the Committee on Headquarters Building; Maurice J. Norby, AHA deputy director; John N. Hatfield, Association treasurer, chairman of the building committee and director of Passavant Memorial Hospital, Chicago; Msgr. Barrett, and Dr. Crosby.

been located in Chicago for 35 years, and the city is pleased that this great organization representing the hospitals of the United States and Canada has seen fit to construct its new headquarters building here."

Dr. Miller observed that the ground breaking ceremonies "mark the first step in the construction of another addition to Chicago as a great medical center." He said, "We welcome as a neighbor an organization which already has accomplished so much to promote the public welfare through the development of better hospital care for all people."

Dr. Miller added, "The central purpose of the AHA and the central purpose of the Northwestern Medical Center and all institutions associated with it are one—to promote the general welfare by working together for better health. I am sure our past accomplishments are but the prelude to an even greater future, a greater future that will come into being in significant part through the activities and programs of the American Hospital Association."

Dr. Edwin L. Crosby, AHA director, presided at the ceremonies. The invocation was offered by the Rt. Rev. Msgr. John W. Barrett, director of Catholic Hospitals of the Archdiocese of Chicago.

WASHINGTON REPORT

One year ago, the dominant health issue before the first session of the 84th Congress was the Administration's reinsurance proposal. As the session progressed, reinsurance and a principal part of the Administration's health program were sidetracked in Congressional committees.

Now, one month before the 84th Congress reconvenes for its final session, there is no single dominant health issue. Reinsurance and other controversial health measures, however, will be carried over from the first session. A brief listing of some of the more important health measures introduced in the first session, but not acted upon, gives some indication of the scope of health legislation to be acted upon in this presidential election year.

BILLS PASSING ONE HOUSE ONLY

Disability Insurance—The House passed, 372 to 31, a series of amendments to the Social Security Act, including compulsory disability insurance for disabled workers who reach the age of 50. This bill is pending in the Senate Finance Committee, and Sen. Byrd (D-Va) has indicated his plans to hold extensive hearings.

Laboratory Research Facilities—This Senate-passed bill is pending before the House Interstate and Foreign Commerce Committee. It proposes a three-year grant program of $90 million to schools of medicine, dentistry and osteopathy, and to hospitals for constructing research facilities for the study of certain specific diseases, such as cancer.

Water Pollution Grants—The Senate voted $2 million annually in grants to prevent pollution of water systems. The House Public Works Committee has held hearings on the bill and has reported it favorably to the House Rules Committee.

NOT ACTED ON, EITHER HOUSE

Reinsurance
Federal Aid to Medical Education
Practical and Professional Nurse Training
Amendments to the Biologics Control Act
Military Dependents' Medical Care
Federal Workers' Health Insurance
Mortgage Loan Guarantees
Military Medical Scholarships.

Out of this backlog of health legislation, plus new legislation introduced in the second session, both Democrats and Republicans will pattern their health programs for 1956.

In a recent television interview, Secretary Folsom of the Department of Health, Education, and Welfare said that he planned no major changes in the health program submitted by the Administration last year. He did indicate, without specifying details, that there might be some modification of the reinsurance proposal.

HEALTH OFFICERS MEET

State and Territorial health officers held their 54th annual conference in Washington Nov. 6-11.

A special session of state medical and hospital facilities survey and construction authorities reviewed progress made under the Hill-Burton Program. The health officers voted to recommend extension of the Hill-Burton Hospital Survey and Construction Act to June 30, 1960. The Act is due to expire in June 1957.

It is expected that bills will be introduced into this session of Congress to authorize such an extension of the Act.

Dr. John W. Cronin, chief of

(Continued on page 148)

Idaho Hospitals Define Stand Regarding Specialist Contracts

During its annual meeting in Pocatello October 11, the Idaho Hospital Association endorsed financial relationships between hospitals and certain medical specialists made by whatever means will "best meet the local situation with due regard to the needs of the patient, the community, the hospital and the physician."

The Association saw as an integral part of the hospital's service to patients such special services as anesthesiology, pathology and radiology. "These services," stated the resolution, "must be furnished at the lowest cost reconcilable with high quality of service."

The Association called for a "reasonable" relationship of income to operating costs of these specialized departments, the costs to include "compensation to any physicians working in or in charge of the department, the direct costs of operating it, and the reasonable pro-rate share of the general hospital operating expenses."

Professional evaluation of the physicians so involved, continued the resolution, must be the "responsibility of the hospital's medical staff, acting within the rules and regulations established by the governing board of the hospital."

In a separate resolution, the Association instructed its counsel to request the Idaho attorney general to "withdraw or revise his outstanding opinions on whether a hospital is practicing medicine . . ." In response to a letter from the State Board of Medicine, the attorney general in May 1954 stated he had come to an "inescapable conclusion . . . that the hospital, and not the patient, compensates the practitioner for services rendered" in hospital radiology, pathology and anesthesiology.

The attorney general stated that "a hospital, if organized for hospital purposes, may erect, own and provide facilities for medical and surgical treatment. However, such powers do not allow or include the practice of medicine and surgery."

His opinion suggested as a possible solution the creation of a "landlord-tenant" relationship between licensed practitioners and the hospital. "There may be other arrangements," continued the attorney general, "but whatever the arrangement is, it should be one whereby the doctor-patient relationship exists."

DECISION EXPECTED SOON—

Iowa Hospital-Physician Case Closes

Testimony in the Iowa hospital-physician court dispute ended November 4 with attorneys for both sides presenting their final arguments.

A decision by Judge C. Edwin Moore was expected in late November. Appeal to the Iowa Supreme Court is expected.

The plaintiff Iowa Hospital Association and 34 member hospitals seek to overturn a 1954 attorney general opinion that hospitals hiring certain medical specialists to operate laboratories are practicing medicine illegally.

The hospitals hold maintenance and operation of laboratories to be within the scope of the Iowa licensure law. They contend the attorney general was not fully informed of all relevant facts when delivering his opinion.

Closing arguments for the plaintiff hospitals summarize testimony they contend proves that:

- Nonprofit hospitals are unique social organizations.
- The role of the pathologist and radiologist is inherently different from that of the clinical physician.
- The present pattern of hospital operation has evolved naturally as a reflection of developments in medical science, as well as individual needs and problems peculiar to the local hospital. This results in a variety of contractual relationships between medical specialists and the hospitals, and indicates the need for continued legal latitude in development of these relationships.
- Many acts performed within the hospital can be termed "not exclusively the practice of medicine"; that is, they may be medical practice if performed by the doctor and not medical practice if performed by some lay person.
- Court decisions in previous cases have recognized the unique social nature of nonprofit hospitals and have exempted them from provisions of the Medical Practice Act.
- A ruling adverse to hospitals would have catastrophic effect upon the present quality and cost of hospital service, and also on the future provision and development of these and similar services.

Defendants in the action are the Iowa Association of Pathologists, the State Board of Medical Examiners and individual Board members. The Iowa Radiological Society and the Iowa State Medical Society have intervened in behalf of the defendants.

Their closing arguments centered on two main points:

- Laboratory and x-ray department operation constitutes the practice of pathology and radiology by pathologists and radiologists. As such, the state's Medical Practice Act prohibits hospitals billing patients for these services.
- Hospital corporations are legally similar to those commercial corporations which courts have prohibited from employing licensed practitioners and advertising the availability of their services, by application of the Act.

Final witnesses appearing in be-

BULLETIN

Judge C. Edwin Moore ruled November 28 that the plaintiff hospitals have been engaged in the practice of medicine.

The ruling stated, "it is the conclusion of the court that plaintiffs are not entitled to operate pathology and x-ray laboratories merely because they have done so for many years . . .

"If the non-profit corporations operating hospitals are to practice medicine it is for the legislature to say . . ."

The court concluded: "That the work done by the pathologist, radiologist and the technicians . . . constitutes the practice of medicine.

"That . . . the privilege of practicing medicine is a personal one requiring qualifications which cannot be met by a corporation.

"That the plaintiff hospitals are not excluded from the requirements of the Iowa Practice Acts on the basis that they are non-profit corporation . . .

"That the plaintiff hospitals . . . have been engaged in unauthorized, unlicensed and illegal practice of medicine."

A spokesman for the Iowa Hospital Association said that an appeal to the Supreme Court was probable, but that it hinged on a careful study of the ruling.

half of the Iowa Hospital Association during its rebuttal were Dr. Albert W. Snoke, director of Grace-New Haven (Conn.) Hospital, and James A. Hamilton, professor of hospital administration at the University of Minnesota, Minneapolis. Dr. Snoke is president-elect of the American Hospital Association and Mr. Hamilton a former AHA president.

In response to questioning, each testified that his appearance did not signify AHA participation.

Policy-making bodies of the American Medical Association, Dr. Snoke declared, have approved any local financial arrangements between hospitals and their physician specialists "so long as physicians' services are not exploited."

In hospitals throughout the nation, he said, "you can find examples of every conceivable (type of) remuneration" between hospitals and pathologists. He termed these "perfectly proper" if neither hospital, physician nor patient is being exploited.

He said it would be unfortunate if a legal straightjacket were imposed, eliminating flexibility in hospital-physician relationships and preventing adjustments to meet local conditions.

CHICAGO MEETING

Dr. Snoke described how he and Dr. Walter Martin of Norfolk, Va., then president of the American Medical Association, suggested during a Chicago meeting that the Iowa Hospital Association and State Medical Society ask the attorney general to withdraw the controversial opinion.

Dr. Francis C. Coleman, president of the Iowa Association of Pathologists, preferred a "trial period" to see whether the hospitals and specialists could reach satisfactory arrangements under the attorney general ruling.

Dr. Snoke said that Dr. Coleman took the position that if satisfactory arrangements could not be reached, then he (Dr. Coleman) and other medical representatives would join hospital representatives in seeking withdrawal of the opinion.

Dr. Snoke said he did not know why the Iowa Hospital Association filed action within 90 days of the Chicago meeting.

Quizzed under cross examination as regards acts in hospitals, he said the practice of medicine "depends on who is actually using the conclusion in the care of the patient." He maintained that this person would be the attending physician.

Dr. Snoke said under cross examination he would "challenge" the contention that the quality of medical care is lower if provided by a salaried physician. "I cannot differentiate between the dedication and the ability" of physicians paid by salaries from hospitals or by patients' fees, he testified.

Dr. Snoke also testified on what he termed "a big bugaboo that's being thrown up"—the contention that the lay board of the hospital can tell the salaried doctor how to practice medicine. The hospital medical staff, he said, is "given the authority to control the medical practice" by the board of trustees.

Mr. Hamilton testified that enforcement of the present Iowa attorney general opinion in his estimation "could be a very dangerous thing." Trustees and private contributors to nonprofit hospitals might "diminish their support," he said, if they felt they were donating even indirectly to the private gain of medical specialists.

Withdrawal of such support, he added, could lead to "disintegration" of the nonprofit hospital.

Mr. Hamilton expressed under cross examination his opposition to any hospital-physician arrangement that would place hospitals in a "straitjacket" regarding their ability to make future services available to patients.

Dr. Walter C. Abbott, Des Moines neurosurgeon and vice president of the State Medical Society, reappeared on the stand briefly for the defendants. He testified to a different interpretation of the Chicago meeting. It was not his understanding, he said, that Dr. Martin suggested to Iowa physicians the withdrawal of the attorney general opinion as the road to agreement between hospitals and specialists.

RAY E. BROWN TELLS REGIONAL GROUP—

Hospital Costs Will Continue to Climb

Hospital costs will continue to increase at about 5 per cent annually for many years unless there is a very significant decrease in the general economic situation, President Ray E. Brown of the American Hospital Association told the 15th annual conference of the Maryland-District of Columbia-Delaware Hospital Association last month.

He said that the annual cost increase could be held to a yearly increment of 5 per cent "only by the best efforts of hospital boards, administrators, medical staff and all of the members of the hospital team."

The factors supporting his forecast, he said, "are built into the nature of the hospitals' operation. The chief factor, and one around which the other factors revolve, has to do mostly with the fact that hospitals are personal service institutions. Personal service spells people instead of machines . . .

"The opportunities for alternative use of machines when the cost of labor exceeds the cost of a machine are not too abundant in the hospital. The same is true of the opportunities for increasing the productivity of our workers by introducing improved equipment and the introduction of the rapidly developing science of automation."

"Most industries have increased productivity per man hour at an annual rate of over 2 per cent for many years," Mr. Brown said. "Since 1946, the increase has averaged 2.9 per cent per year for the nation as a whole. This increased productivity has been the cushion by which much of the increased wages to labor have been absorbed . . . The nature of the hospital's work provides little opportunity for such productivity gains. Nonetheless, hospital salary levels are

Dr. Russell A. Nelson, director of the Johns Hopkins Hospital, Baltimore, is new president-elect of the Maryland-District of Columbia-Delaware Hospital Association.

Elected first vice president was Victor F. Ludewig, superintendent of George Washington University Hospital, Washington. The second vice president is Sister Mary Thomas, administrator of Baltimore's Mercy Hospital; and the third vice president is Wilbur C. Anderson, executive director, Emily P. Bissell Sanitarium, Wilmington.

Secretary of the Association is Maurice W. J. Abraham, administrator of Kent General Hospital, Dover, Del. C. Parker Sheppard, comptroller of Lutheran Hospital, Baltimore, was reelected treasurer.

During the meeting, Glenn A. Fisher was installed as president, succeeding Fred A. McNamara. Mr. Fisher is administrator of Nanticoke Hospital, Seaford, Del.

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tied directly to general salary levels.

"Under such circumstances, every round of salary increases constitutes a direct increase in hospitals' costs. Over the years ahead, as the general labor force receives its rightful share of the proceeds from increased productivity, the hospitals and other personal service industries will be compelled to give the same rewards without the full benefit of such increased productivity . . .

"It is inescapable that the costs of hospital care will follow very closely the constantly increasing real wage of industry. This means that while a day's work will each year buy an increasingly larger amount of most things, it will not buy the worker an increased amount of hospital care."

In another session, Malcolm C. Hope, chief, General Engineering Program, Division of Sanitary Engineering Services, Public Health Service, described some of the newer testing programs in food sanitation. He said that there were many bactericidal agents on the market but that there had been no good field tests of these agents and that the Public Health Service had no opinion on the efficacy of these proprietary products.

At the business session of the Association, Harvey H. Weiss, executive director, Sinai Hospital of Baltimore, reported that an increase in the payments by government for the care of indigent and medically indigent in hospitals was going to be forthcoming.

Joint Blood Council Formed; Set Up National Headquarters

The Joint Blood Council announced establishment November 1 of its national headquarters in Washington. Dr. Frank E. Wilson, former director of the American Medical Association's Washington office, has been elected executive vice president and secretary.

The Council is a voluntary group formed by the five national associations principally concerned with procuring, processing, preserving and distributing blood and blood derivatives. Its objective is to coördinate all activities in the field, including blood interchange, standardization of cross-matching and typing procedures, accreditation and inspection of blood banks, stimulation of blood donor campaigns and encouragement of research.

Joined in the new venture are the American Association of Blood Banks, American Hospital Association, the AMA, the Red Cross and the American Society of Clinical Pathologists.

Dr. Leonard W. Larson of Bismarck, N. D., representing the AMA, is president of the Council. Dr. Merlin L. Trumbull of Memphis, American Association of Blood Banks, is vice president, and Dr. Karl S. Klicka of Chicago, AHA, is treasurer.

Sign Out-of-Court Agreement In Washington Suit by Dr. Mousel

An out-of-court agreement was signed September 30 in the Washington state case filed by Dr. Lloyd H. Mousel, Seattle anesthesiologist, against eight medical groups and their officers.

Dr. Mousel, director of the department of anesthesiology and oxygen therapy at Swedish Hospital, Seattle, had charged conspiracy by these groups to prevent him and other such specialists from rendering services of any type on salary to any hospital in the city and in King County.

The case was originally scheduled for trial October 10. Settlement agreements were signed following postponement. The agreement proposes a hearing "as near as practicable to December 15," at which time the suit presumably will be withdrawn if terms of the settlement are fulfilled.

The agreement states in part:

"No salary, stipend or other form of compensation shall be paid by the hospital (either directly or indirectly) to Dr. Mousel or any other anesthesiologist for medical services rendered by them directly or indirectly to patients, including the supervision, assistance, advice or guidance of nurse anesthetists for whose services the hospital makes a charge to patients. In any case where Dr. Mousel personally supervises, assists, advises or guides a nurse anesthetist administering anesthesia, or renders professional services to the patient preliminary or subsequent thereto, Dr. Mousel shall make a reasonable charge to the patient for the performance of such services except in those cases where in Dr. Mousel's professional judgment no charge should be made, and any other anesthesiologist rendering such services may make such a charge to the patient if he so desires.

"In such cases the hospital may, with the consent of the anesthesiologist involved, bill the patient in his behalf and as his agent, and shall remit all receipts therefor to him. In such cases the amount being billed for the anesthesiologist's services shall be clearly identified as such and separately stated on the face of the bill. The contract between the hospital and Dr. Mousel will provide that such billings will be made by the hospital as his agent. No charge will be made by the hospital to any patient, nor rebate accepted by the hospital for services rendered to that patient by any anesthesiologist or anesthesiology resident."

The hospital is allowed to charge the anesthesiologist for "all direct and indirect expenses incurred . . . plus a reasonable allocation of depreciation (but not including any loss of income, loss of profit, or any compensation paid to any anesthesiologist by the hospital for the teaching and training of anesthesiology residents), directly attributable to the maintenance of said anesthesiology resident training program."

On its part, the King County Medical Society board of trustees agrees to recommend that Dr. Mousel be admitted to its membership and membership in each of the following groups: Washington State Society of Anesthesiologists, Inc., Washington State Medical Association, King County Medical Service Bureau, American Society of Anesthesiologists, American Medical Association.

Dr. Mousel's complaint, filed June 9 in King County Superior Court, alleged that his application for membership in the county medical society had been thrice turned down because of the salary arrangement he had with Swedish Hospital. He also stated his membership in the American Society of Anesthesiologists had been dropped and that he had been notified the American Board of Anesthesiology was considering dropping his membership and decertifying him.

Sociologist Reports Discontent With Hospitals Is Widespread

Nearly three-quarters of the people have a "pronounced unfavorable reaction" to care given them in hospitals, the American Public Health Association was told November 17.

The Association, gathered in Kansas City for its 83rd annual

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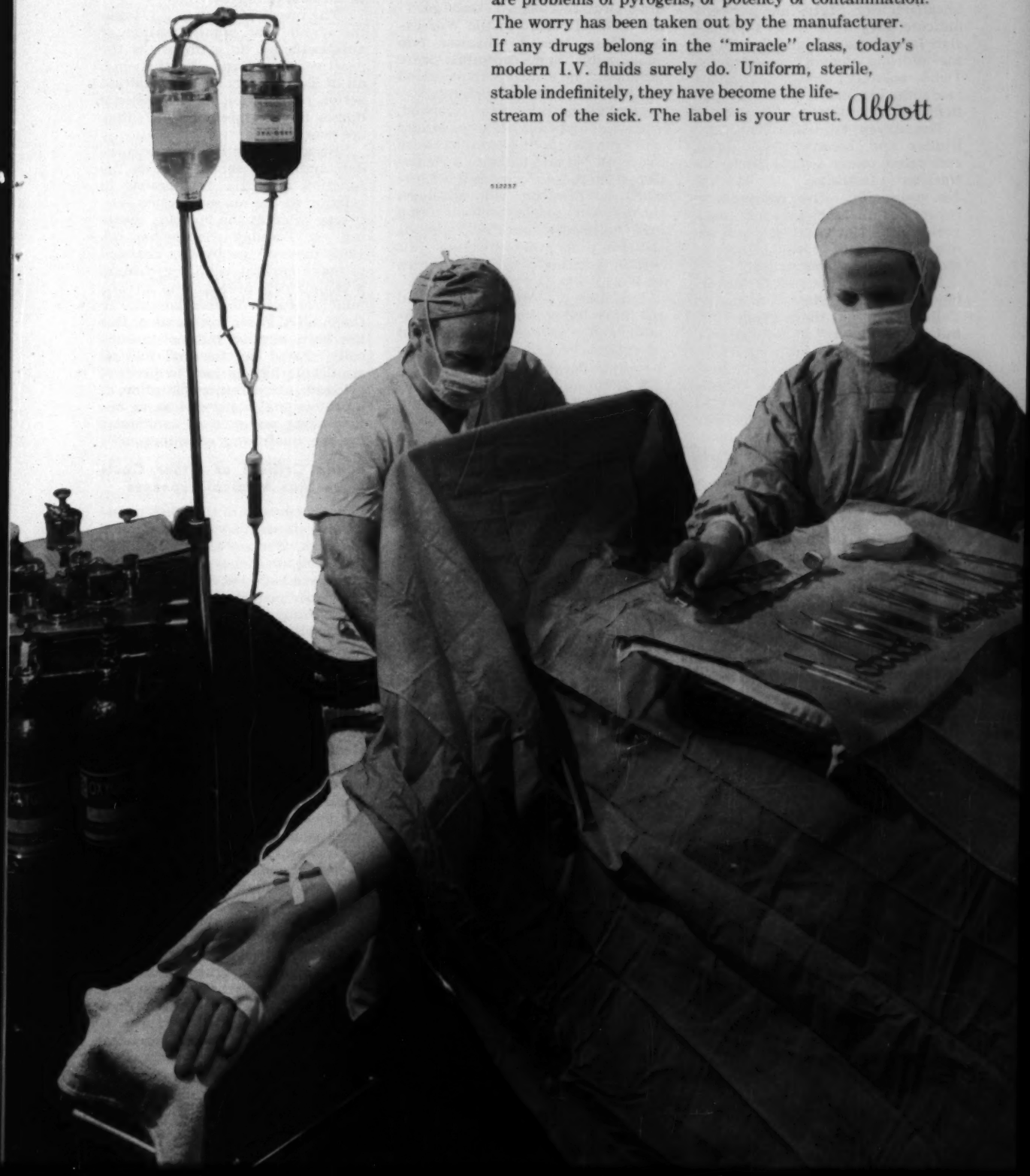

meeting, heard a preliminary report by Florida sociologist Earl Lomon Koos on a survey indicating that 82 per cent of the people think hospital costs too high and 71 per cent think hospital care unsatisfactory. Sixty-four per cent indicate they feel today's physician lacks "the human warmth of the oldtime general practitioner (who possibly knew less about medicine but more about his patients)," according to Mr. Koos.

The survey, on urban health attitudes and behavior, has been conducted under grants from the National Institutes of Health, Bethesda, Md. The preliminary report covers 1,000 persons interviewed in a Northeastern U. S. industrial city of 350,000, anonymously called "Metropolis."

Mr. Koos, professor of sociology at Florida State University, Tallahassee, said there appear "no mitigating factors" in respondents' attitudes toward hospital costs. Responses to questions about hospital care, however, were "qualified," he said. Respondents seemed to feel they were "just somebody filling a bed," he added, a reaction not confined to any one sociological level.

He declared that while the hospital, as well as the doctor, "is caught in the coils of an advancing medical technology," many ills in hospital-doctor-patient relationships today seem to stem from the feeling that "the patient has been somewhat forgotten in the course of hospital progress."

Quality of Care and Education Threatened, ACS Congress Told

More than 10,000 surgeons and guests were on hand for the 1955 Clinical Congress of the American College of Surgeons in Chicago.

Featured papers were given by Grayson L. Kirk, president of Columbia University; Dr. Frank B. Berry, assistant secretary of health, and Dr. Warren H. Cole, incoming ACS president.

The College's Board of Regents ruled the matter of "excessive fees" to a special board committee for study.

Dr. Daniel Collier Elkin of Atlanta was named president-elect of the College.

President Kirk, delivering the annual Martin Memorial Lecture, said the quality of medical education and medical care for the future are being threatened today by abandonment of the principle of fulltime teaching and research in medical schools. Too many teachers, he warned, are turning to private practice, with its greater financial reward.

Dr. Berry, delivering the Trauma Oration, termed "not good" the medical record in the Worcester, Mass. tornado disaster two years ago. "Some hospitals were jammed," he said. "Others stood half-empty, awaiting patients.

"In the confusion that followed, entrances and exits became blocked with traffic and hospitals were overcrowded and failed to send patients on to less crowded institutions . . . Surgeons who had been in the war forgot their training and hurriedly sutured wounds without proper debridement—this within a decade of our experiences in World War II and Korea . . ."

Dr. Berry emphasized sound planning for sorting, rapid evacuation and dispersion in the event of disaster. As phases of the preparatory program, he outlined:

- Local and area-wide coöperation with civil defense authorities in organizing medical personnel.
- Accumulation and storage of medical supplies.
- Universal immunization against tetanus.
- Universal blood typing and marking, including tattooing of the type on every individual.
- Emphasis on principles of traumatic surgery in surgical teaching.

Dr. Carl Walter of Boston, speaking on "the operation as a bacteriological hazard," criticized hospitals for what he termed a campaign of "organized neglect" on operating room cleanliness.

Maids and orderlies, he declared, are not doing a thorough job of cleaning. They are leaving hidden dirt in halls and operating rooms that serve as breeding sites for airborne bacteria. He termed the condition "widespread."

Dr. Walter suggested that hospitals in the past have been able to "get by" because antibiotics could quickly knock out any infection that occurred in the surgical patient. But now, he said, there is an increasing resistance on the part of many germs.

The infections are causing increasing sickness, longer stays in hospitals and occasionally a death, he said.

Dr. Walter's remarks were challenged by other surgeons from the floor.

AANA Trustees Declare Nurse Registration Mandatory

The American Association of Nurse Anesthetists has routed the following letter to all state boards of nurse examiners:

"The board of trustees . . . takes the stand that administration of anesthesia by its members is the practice of nursing. To this end, all of its members should maintain active registration as professional nurses in the states in which they are working.

"Because there has been misunderstanding in the past as to the function of nurse anesthetists in relation to the nurse practice acts, it was voted at the business meeting on Tuesday, September 20, 1955, to have the bylaws changed to make current valid registration a mandatory prerequisite to annual renewal of membership in the AANA. Prior to this time, this has been implied but not specifically stated in the bylaws—all applicants having had to produce evidence of current registration as a professional registered nurse before being accepted as candidates for the qualifying examination."

Public Critical of Other Costs More than Medical Expenses

Forty per cent of the adult population believe food costs are much too high. Forty-five per cent believe repair charges (on TV, autos, etc.) are excessive. Twenty-seven per cent are equally critical of clothing costs. Twenty-six per cent believe the cost of medical care is much too high.

These figures are from a preliminary report on a national survey of opinions and attitudes toward medical care just released to the pharmaceutical industry by Health Information Foundation, New York. The survey is being conducted under a grant from the Foundation to the National Opinion Research Center of the University of Chicago.

George Bugbee, Foundation president, said these are partial and preliminary results. He said that the total study is designed to determine how public opinions and attitudes affect the use of services of physicians, hospitals, dentists and the drug industry, as well as voluntary health insurance.

Of special interest were finding that:

- While medical costs in general come in for less criticism than other elements of the cost of liv-

ing, the percentage believing medical costs to be "much too high" cite in particular doctors' fees (16%), hospital charges (39%), dentists' fees (24%) and prescriptions at drug stores (38%).

▸ Among those saying drug costs are much too high, analysis by education shows little variation. Thirty-seven per cent of those attending college are critical, as are 36 per cent of those attending high school and 40 per cent of those with grammar school education.

▸ Income does not affect degree of criticism. Thirty-eight per cent with $3,000 income or less say drugs are too high, and 37 per cent of those with incomes of $5,000 or greater are critical.

Ten State Hospital Associations Report Election of New Officers

Ten hospital associations have recently elected the following officers at their annual meeting:

British Columbia Hospitals' Association: President, J. A. Abrahamson, hospital chairman, Queen Victoria Hospital, Revelstoke; first vice president, L. F. C. Kirby, director, Royal Columbian Hospital, New Westminster; second vice president, H. R. Slade, administrator, General Hospital, Powell River; secretary-treasurer, Percy Ward, North Vancouver.

California Hospital Association: President, Fred W. Moore, administrator, Rideout Memorial Hospital, Marysville; president-elect, Dr. W. W. Stadel, administrator, San Diego County General Hospital, San Diego; treasurer, Clifton H. Linville, administrator, Fresno Community Hospital.

Idaho Hospital Association: President, Roy C. Stephenson, administrator, Latter Day Saints Hospital, Idaho Falls; president-elect, Mrs. Irene Oliver, administrator, Magic Valley Memorial Hospital, Twin Falls; first vice president, Sister Mary Austin, superintendent, Mercy Hospital, Nampa. Owen P. Hatley, administrative assistant to the State Board of Health, Boise, was reelected secretary-treasurer.

Indiana Hospital Association: President, Sister M. Vetusa, R.N., St. Catherine Hospital, East Chicago; president-elect, Herbert A. Schacht, administrator, Henry County Hospital, New Castle; first vice president, Olive M. Murphy, administrator, Bartholomew County Hospital, Columbus; treasurer,

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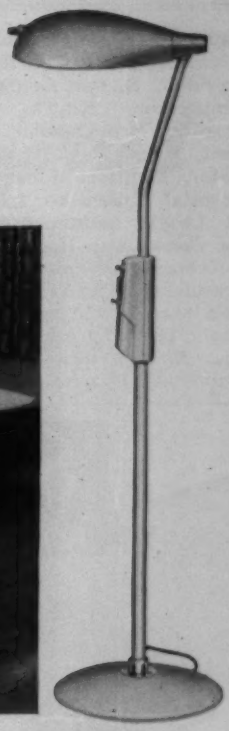

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Mississippi Hospital Association: President, S. Earl Grimes Jr., administrator, King's Daughters Hospital, Brookhaven; president-elect, Harry C. Cutler, administrator, Montfort Jones Memorial Hospital, Kosciusko; treasurer, D. A. Lingle, administrator, Jones Co. Community Hospital, Laurel.

Nebraska Hospital Association: President, John L. Hurley, business manager, St. Francis Hospital, Grand Island; president-elect, Duane E. Johnson, administrator, University Hospital, Omaha; vice president, Sister Olive Cullenberg, administrator, Immanuel Hospital, Omaha; secretary, James A. Canedy, assistant hospital administrator, Bishop Clarkson Memorial Hospital, Omaha.

Sister Mary Kevin, director of nursing at St. Catherine's Hospital, Omaha, was reelected treasurer.

Vermont Hospital Association: President, Mary M. Ferry, administrator, Heaton Hospital, Montpelier; president-elect, John Stone, administrator, Putnam Memorial Hospital, Bennington.

Reelected to the posts of secretary and treasurer were Glenn M. Corey, administrator, Porter Hospital, Middlebury, and Gertrude K. Trout, administrator, Brightlook Hospital, St. Johnsbury.

Washington State Hospital Association: President, Paul S. Bliss, administrator, Vancouver Memorial Hospital, Vancouver; president-elect, Sister Agnes of the Sacred Heart, administrator, Providence Hospital, Seattle; first vice president, Mrs. Charlotte Dowler, administrator, Shelton General Hospital, Shelton; second vice president, Chester Finkbeiner, administrator, Central Washington Deaconess Hospital, Wenatchee; third vice president, Lillian McDonald, administrator, Memorial Hospital, Sedro-Woolley.

Reelected treasurer was Martin N. Olsen, business manager of Swedish Hospital, Seattle.

West Virginia Hospital Association: President, James E. Huson, superintendent, Camden-Clark Memorial Hospital, Parkersburg; president-elect, Carl C. Drewry, administrator, Raleigh General Hospital, Beckley; vice president, Sister M. Pia, administrator, Vincent Pallotti Hospital, Morgantown; treasurer, J. H. Laughlin, administrator, Staats Hospital, Charleston.

Wyoming Hospital Association: President, Earl S. Ireland, administrator, Memorial Hospital of Sheridan County, Sheridan; president-elect, James G. Carr Jr., administrator, Memorial Hospital of Natrona County, Casper; secretary, Elaine McGaugh, R.N., superintendent, Memorial Hospital of Carbon County, Rawlins; treasurer, Ray Watkins, business manager, Memorial Hospital of Natrona Co.

Michigan Hospital Reports Treating 'Missing Patient'

A patient using the name Leo Lamphere and giving as his address 55 W. 20th St., New York City, was admitted July 12 to University Hospital, Ann Arbor, Mich. He was discharged August 8, leaving the hospital to "write off" the charges incurred.

This man said he was born December 23, 1913. He is 5′ 8½″ tall and weighs 258 lbs. He presented a thrombophlebitis of the leg and gave a classical history (without questioning) of a pulmonary embolus. While in the emergency room he "coughed up" blood. He was very well versed in all signs of pulmonary infarction.

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Belatedly, University Hospital discovered this man was the subject of an article, "Missing Hospital Patient," which appeared in the March 5 *Journal of the American Medical Association*, Vol. 157, No. 10, p. 842. His performance in this hospital followed that description exactly. As in the other hospitals, no positive evidence of chest pathology was found. His deportment on the nursing unit wreaked havoc with the staff.

Dr. Dean W. Roberts to Direct Society for Crippled Children

Dr. Dean W. Roberts of Baltimore has been appointed executive director of the National Society for Crippled Children and Adults.

Dr. Roberts, since 1952 director of the National Commission on Chronic Illness, succeeds Lawrence J. Linck. No date has been set on which Dr. Roberts will assume his new position.

Mr. Linck will continue to serve the Society as counselor and voluntary trustee-at-large.

Mrs. Price Named New Director At Johns Hopkins Nursing School

Mrs. Mary Sanders Price of Johnstown, Pa., has been appointed director of the Johns Hopkins School of Nursing and Nursing Service, Baltimore.

She assumed her new position December 1, succeeding Anna D. Wolf, who retired last June.

The new director, a 1934 graduate of the Johns Hopkins School of Nursing, has served in a wide variety of nursing positions—direct patient care, nursing education and administration—at Johns Hopkins and other medical institutions.

FCDA Announces Release Of 26 'Impros' for Local Display

Twenty-six improvised hospitals will be distributed shortly to cities in all regions for training and display purposes, to aid in promotion of the Federal Civil Defense Administration hospital program.

Selection of the first 26 display cities will be made on the basis of negotiations between state civil defense and FCDA regional officials. Displays are subject to rotation among cities in each region.

FCDA will pay the cost of transporting the "impro" from stockpile warehouse to display city and for subsequent shipment from one state to another. Exhibit

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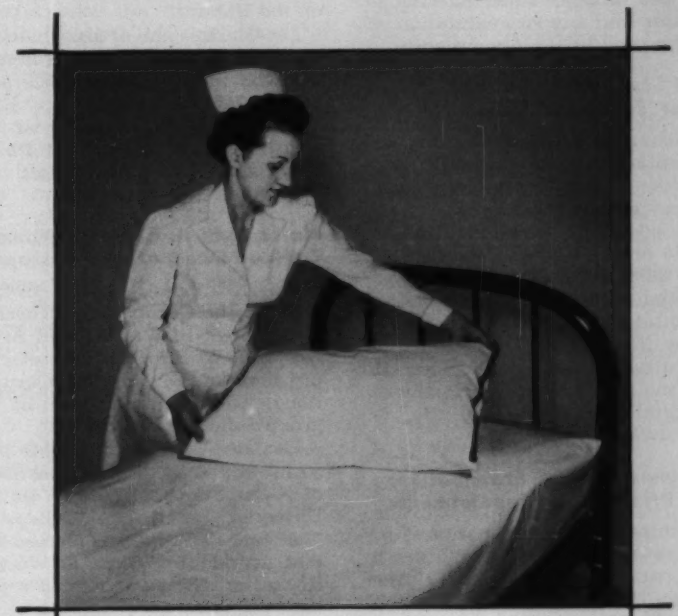

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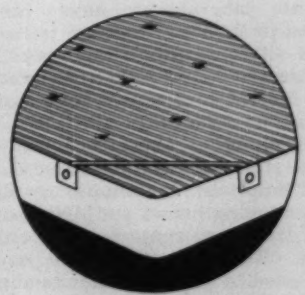

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maintenance and staffing costs in a particular city will be borne by the state involved.

Hospitals are urged through their state hospital association to contact local defense officials and the director of civil defense health services in their state, offering to sponsor and support exhibition of an "impro" in their community.

Two State Associations Name Executive Secretaries

Richard P. MacLeish, hospital consultant for the Colorado State Health Department, has been named executive secretary of the state hospital association. The Colorado hospital group established a full-time secretariat October 1.

Ralph W. Nelson, former Oregon Hospital Association president, became the Association's part-time executive secretary November 15. His mailing address is Northwest Hospital Service, 1320 S. W. Broadway, Portland 7.

Announce March Examinations For PHS Officer Appointments

Competitive examinations for appointment of medical officers to the regular corps of the United States Public Health Service will be held March 20-22.

Candidates will be tested at the examining center nearest their homes. Applications must be in the hands of the Public Health Service no later than February 10.

Application forms and accompanying information on the examinations may be obtained by writing to the Chief, Division of Personnel, Public Health Service, Department of Health, Education and Welfare, Washington 25, D. C., or from PHS field stations.

Mrs. Cooksey President-Elect Of American Record Librarians

Mrs. Eddie Cooksey, chief medical record librarian at Charity Hospital, New Orleans, was named president-elect of the American Association of Medical Record Librarians during the annual meeting October in Chicago.

Installed as Association president was Dorothy Kurtz, chief medical record librarian at the Columbia - Presbyterian Medical Center, New York City. Sister Mary Yvonne, chief librarian at Firmin Desloge Hospital, St. Louis, was elected first vice president. Second vice president is Helen Waterman, chief librarian, U. S. Naval Hospital, Oakland.

Dr. Clark President of National Commission for Improved Care

Dr. Dean A. Clark, director of Massachusetts General Hospital, Boston, has been named president of the National Joint Commission for the Improvement of the Care of the Patient.

Dr. Clark is one of six American Hospital Association representatives on the Commission. He succeeds Mathilda Scheuer, R.N., assistant general director of the Visiting Nurse Society of Philadelphia, an American Nurses' Association representative.

Major Ruth A. Robinson Named To Head Occupational Therapists

Major Ruth A. Robinson, AMSC, chief of the Occupational Therapy Department in Walter Reed Army Hospital, Washington, was elected president of the American Occupational Therapy Association at the group's annual conference.

Beatrice D. Wade, associate professor and head of the Department of Occupational Therapy in the University of Illinois College of Medicine, Chicago, was elected first vice president. Wilma L. West of Rochester, N.Y. was named treasurer-elect.

Washington report

(Continued from page 138)

HEW's Hospital and Medical Facilities Division, said, "There have been nearly 2,600 projects approved with 120,000 beds; 1,800 projects with 85,000 beds have been completed and are serving their communities.

"In addition to these new beds, 550 public health centers, many related health facilities and state health laboratories have been aided in their construction phases. This all represents a total expenditure of over $2 billion, of which the federal government contributed about $700 million."

Speaking of experience gained from states' plans for chronic disease hospitals, rehabilitation facilities, nursing homes and diagnostic and treatment centers, Dr. Cronin said, "These programs are new. We need to develop understanding about them in the states as well as among ourselves, as was done in the original Hospital Survey and Construction Program."

He declared that new levels of hospital utilization and reduced length of stay are examples of changes for which careful plans must be drawn.

SURPLUS PROPERTY

HEW announced that under the government surplus property program, valued at more than $56 million, equipment was distributed to the states for educational and public health purposes during July, August and September. Items transferred to the states included school and hospital building sites, hospital furniture, machine tools, laboratory equipment and office supplies.

FEDERAL NARCOTICS LAW

The Treasury Department's Bureau of Narcotics, in an official letter, has reminded hospitals that under the terms of the Federal Narcotic Law every physician or practitioner must register and pay a special tax to lawfully administer and dispense narcotic drugs to patients. A physician who desires to register under the Federal Narcotic Law must do so in the state where he practices. Registration in one state will not cover his activities in another state.

TAX COURT DECISION

In a September decision, the District of Columbia Tax Court ruled that university property transferred without profit is not taxable. The particular case involved was the American University. In its ruling, the Court stated that tax-exempt land owned by a university is not taxable when transferred without profit to a hospital association for building purposes.

HOSPITAL RESEARCH

More than 50 applications for allocations from the $1.2 million federal fund to finance research in hospital activities had been made to October 21, deadline for the first allocations. Requests for research totaling over $2.3 million came from universities, hospitals and various professional and voluntary associations, including the AHA.

At its December meeting, the Federal Hospital Council will probably approve between $700,000 and $800,000 in grant applications to nongovernmental research organizations. The balance of the $1.2 million will be allocated during the Council's spring meeting.

Final decision on grants will be made by the surgeon general of the Public Health Service.

SELECTIVE SERVICE CALL

The Department of Defense is requesting 119 dentists for induction during December and 297 physicians (since revised to call only 150) for induction in February 1956. The Secretary of Defense memorandum requests that state Selective Service directors submit a report on the number of physicians who are special registrants qualified in Class 1-A or 1-A-O, examined, acceptable and available as of November 1, 1955.

Excluded from the list are (1) physicians who will be 46 years of age or older on February 25, 1956; and (2) physicians who will be 35 years of age or older on February 25, 1956, and have applied at any time for a commission in one of the armed forces in a medical, dental or allied specialist category and have been rejected for such commission solely because of physical disqualification.

MEDICAL MUSEUM PROPOSAL

Senators Lister Hill (D-Ala) and John Kennedy (D-Mass) recently held a conference with public representatives to discuss terms of a proposed bill for a museum of medical history. Representatives to the special conference included the AHA, AMA, American Public Health Association and the Cleveland (Ohio) Health Museum.

STUDY WELFARE, HEALTH PROGRAMS

The Congressional Joint Economic Committee has commenced hearings on social insurance and federal welfare and health programs under a special subcommittee headed by Sen. John Sparkman (D-Ala). The Congressional committee will emphasize problems of low-income families. Special topics to be taken up by the Sparkman subcommittee will be:

(1) Urgent health needs of the low-income urban and rural families; (2) federal aid to make necessary health care available to these low-income groups; (3) identifying existing gaps in government-sponsored economic security programs.

This Sparkman committee could very well prove to be a sounding board for Democratic party policy in the health field. The AHA will submit a statement on its views.

CARE FOR MILITARY DEPENDENTS

A high ranking military officer has taken a stand against health care for servicemen's dependents by civilian doctors and hospitals.

In an address at the opening session of the 62nd annual convention of Association of Military Surgeons in Washington November 7, Air Force Surgeon General Dan C. Ogle said that ". . . we should take the position that a major portion of such care be provided in military clinics and hospitals, by military doctors . . ."

Gen. Ogle urged Congressional enactment of the pending Administration military dependent medical care bill (S.2720) which clarifies governmental responsibility for health care of military dependents. Despite its vagueness in certain respects, he indicated it is preferable to H. R. 7806 bill of Rep. Price (D-Ill) which stresses utilization of civilian hospitals rather than military.

HOSPITALS AND PHILANTROPHY

A report recently issued by Social Security Administration includes statistics on philanthropic support of hospitals and its contribution to their growth.

In 1952, living donors accounted for 89 per cent of $5 billion contributed by Americans for all philanthropic purposes. Corporations gave 8 per cent; the other 3 per cent came from bequests.

Approximately 27 per cent of the total went to secular health and welfare agencies, including hospitals and clinics, community chests, Red Cross and others.

Between 1930 and 1945, all hospital construction in this country averaged about $100 million a year, with state and local governments bearing two-thirds of the burden and philanthropy financing most of the balance.

With the postwar advent of the Hill-Burton program hospital construction rose sharply—from $349 million in 1948 to $867 million in 1952. Private hospital building went from $85 million in 1946 to $344 million in 1950 to $394 million in 1952, with philanthropy paying about one-half the bill.

HOSPITAL CONTRUCTION

First ten months of 1955 witnessed a substantial gain in private hospital and institutional construction, compared with same period in 1954. On the other hand, there was a drop in public hospital building.

According to figures prepared jointly by Departments of Commerce and Labor, new construction activity totaled more than $36 billion, of which $580 million was hospitals and institutional: $295 million private and $285 million public. In the first category, a 6 per cent increase over same period in 1954 was noted, in contrast with a 9 per cent decline in public hospital construction.

BLUE CROSS

All Member Plans Enrolled In Bank, Transfer Agreement

One hundred per cent participation in the Inter-Plan Service Benefit Bank and Inter-Plan Transfer Agreement—two national reciprocity agreements of approved Blue Cross Plans—became a fact October 1.

With admission of the Rhode Island Plan to the Inter-Plan Bank and the New Jersey Plan to the Transfer Agreement, subscribers of all 86 AHA-approved Plans in the United States, Canada and Puerto Rico now are covered by the national agreements.

The Inter-Plan Service Benefit Bank, started in 1949, provides benefits to members of Plans hospitalized outside their own home area. Through the Bank, the subscriber's home Plan is charged for care received in out-of-area hospitals. In 1954, the Bank cleared 241,115 cases, an all-time high, with a payment of more than $30 million. In all, 937,681 cases have been cleared with a resulting transfer of more than $102 million.

Entire Indian Tribe Enrolls In Blue Cross, Blue Shield

An Indian tribe has signed up for Blue Cross-Blue Shield coverage.

Effective in mid-November, the 554 members of the Southern Ute Indian tribe, with headquarters at Ignacio, Colo., are covered by the Colorado Blue Cross and Blue Shield Plan.

Officials of both tribe and Plan say this marks the first time an

Indian tribe with no financial assistance from the government has joined a private organization for hospital and medical care.

J. A. Rowland Executive Director Of Arkansas Prepayment Plans

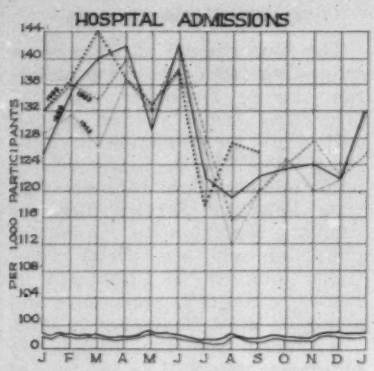
The appointment of John A. Rowland as executive director of Arkansas Blue Cross and Blue Shield Plans, effective December 1, has been announced. Mr. Rowland succeeds Mr. Jack L. Redheffer, who died this past summer.

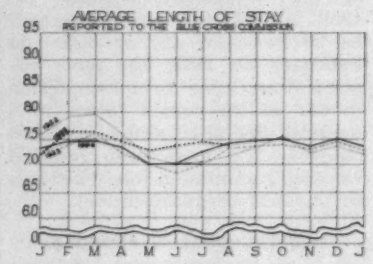
Mr. Rowland, 43, is one of the founders of the Arkansas Plan and served as one of its directors for six years.

Dr. R. J. Novy Resigns Post; Successor is Dr. Haughey

Dr. Robert J. Novy recently resigned as president of Michigan Medical Service, following a long and distinguished career in Blue Shield activities.

He is succeeded by Dr. Wilfrid Haughey, editor of the *Journal of the Michigan State Medical Society* since 1942.





ADMISSION-STAY

The admission rate during September was 126 inpatients per 1,000 members. This marks a decrease of one per 1,000 members over experience of the previous month.

The average length of stay for hospitalized Blue Cross members decreased from 7.47 days in July to 7.40 days in August.

Blue Cross Plans provided an average 919 days per 1,000 members in August. This marks an increase of 73 days per 1,000 members over the July experience.

OFFICIAL NOTES

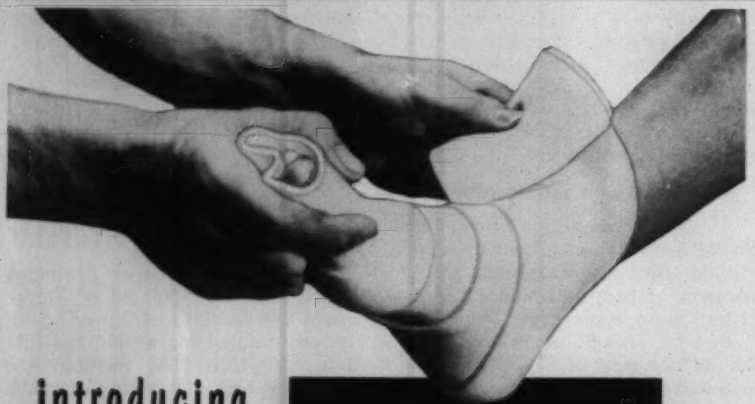
(Continued from page 137)

possible, provide for matching by the political subdivisions of the states.

6. The percentage of federal participation for federal funds on a matching basis should vary with the wealth of the state, ranging from 33 1/3 to 75 per cent. There should be no stated dollar limit on the federal grants.

7. The legislation shall provide for the issuance of administrative regulations and such regulations should provide for minimum standards of health care to be provided.

8. Responsibility for the adminis-



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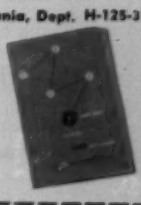

tration of the program shall be vested in the surgeon general of the United States Public Health Service.
9. The legislation shall set forth the broad general principles under which the states may participate in the program. Each state, to participate in the program, must submit a state plan in accordance with detailed specifications provided by the surgeon general as outlined in these broad principles.
10. There shall be an advisory council composed of eight members appointed by the secretary. Four of the eight members shall be persons who are outstanding in fields pertaining to hospital and health activities and the other four members shall represent the consumers of hospital services and shall be persons familiar with the need for hospital services in urban and rural areas. The surgeon general shall consult with and submit all specifications and administrative regulations to the advisory council for approval.
11. As one of the possible methods of encouraging the states to participate in the provision of care for public assistance recipients, a special pool of federal funds shall be established to be administered by the surgeon general for the purpose of conducting studies of experience under the Act and to determine improvements in care rendered.
12. State plans, to be developed by each individual state and submitted to the surgeon general for approval, must provide for minimum standards of hospital and medical care, the kind and eligibility of hospitals and for care rendered only by persons licensed under state law to practice medicine, surgery and nursing.
13. The state plan should provide for general standards of administration.
14. A state plan must provide that it shall be in effect in all political subdivisions of the state and, if administered by them, be mandatory upon them.
15. The legislation shall provide for an advisory council within each individual state in the same manner that such council is provided for at the federal level.
16. Federal funds appropriated under this Act may be used only for the provision of health services to recipients of public assistance and for no other purpose. Federal funds may not be used as a substitute for present appropriations for health services, except in a substitute for present appropriastates which now provide for full cost of health services.

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Massachusetts Memorial Hospitals, Boston, celebrated its centennial last month by staging an all-day series of conferences by national health authorities.

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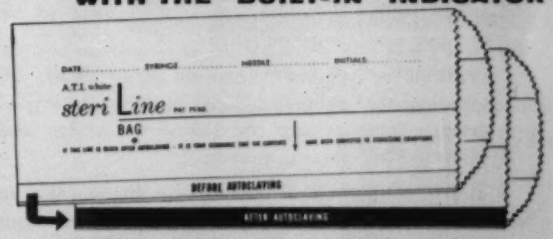

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Malakoff—Kilman Hospital
Refugio—Refugio County Hospital
San Antonio—St. Benedict's Hospital

CANADA

Saint-Jerome, Que.—Hotel-Dieu de Saint-Jerome
Vancouver, B. C.—The Salvation Army Grace Hospital

PERSONAL

Becker Jr., Charles — Adm. — Davidson County Tuberculosis Hospital—Nashville
Biz, G. Robert—Student—University of Michigan—Ann Arbor
Boehme, Donald—Student—Northwestern University—Chicago
Boughton, Gordon S.—Student—Northwestern University—Chicago
Brenneman, Pauline E.—R.R.L.—St. Joseph Hospital—Lorain, Ohio
Byram, Thomas Leslie—Student—Northwestern University—Chicago
Cooper Jr., Charles M.—Student—Northwestern University—Chicago
Croes, Jack W.—Adm.—Marlette (Mich.) Community Hospital
Dimendberg, David Charles—Student—University of Michigan—Ann Arbor
Finger, Mary Lou—Student—Northwestern University—Chicago
Gifford, Richard D.—Student—University of Chicago
Graham, Mrs. Vera—R.R.L.—The City Hospital—Bellaire, Ohio
Gregoric, Florence I.—Adm. Asst.—Malden (Mass.) Hospital
Hain, Andrew A.—Student—University of Minnesota—Minneapolis
Hubbard, Jr., Fred C.—Adm.—Gaston Memorial Hospital—Gastonia, N. C.
Hunt, 1st. Lt. Clyde T., USAF (MSC)—Chief Med. Staffing & Education—Office of the Surgeon—March Air Force Base, Calif.
Hutchinson, Joseph I.—Student—Northwestern University—Chicago
Irwin, Lawrence E.—V. P.—Hospital Service Association of Pittsburgh
Katz, Moshe—Student—University of Toronto—Toronto, Ont., Can.
Kozina Jr., Nandor—Asst. Head—Records Branch—U. S. Naval Hospital—Camp Lejeune, N. C.
Lane, Joseph K.—Asst. Adm.—St. Joseph's Hospital—Fort Worth, Tex.
Leslie, Artemas C.—Blue Cross Commission—Washington, D. C.
Miller, Andrew A.—Asst. Dir.—Mount Vernon (N. Y.) Hospital
Mouish, Arnold E.—Student—Northwestern University—Chicago
Oling, Marie N.—Student—Northwestern University—Chicago
Olsen, Richard L.—Adm. Res.—Vancouver (B. C., Can.) General Hospital
Post, Gladys E.—Student—Northwestern University—Chicago
Rodriguez, Jesus M.—Student—Columbia University—New York City
Shaw, Maurice B.—Student—Northwestern University—Chicago
Siegel, Sydney—Asst. Pur. Agt.—Mount Sinai Hospital—New York City
Sledge, Victor M.—Student—Northwestern University—Chicago
Wilpitz, Roland Willie—Student—Northwestern University—Chicago

NEW AUXILIARY MEMBERS

Women's Auxiliary of Park City Hospital, Bridgeport, Conn.
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Mary Chiles Hospital Woman's Auxiliary, Mt. Sterling, Ky.
Women's Auxiliary to St. Mary's Hospital, Kansas City, Mo.
Women's Auxiliary of the Monticello (N. Y.) Hospital
The Auxiliary of The Keeley Institute, Greensboro, N. C.
Joint Township District Memorial Hospital Auxiliary, St. Marys, Ohio
Beaumont (Tex.) Municipal Hospital Auxiliary
Dr. W. H. Groves Latter-Day Saints Hospital Auxiliary, Salt Lake City
Harrison Hospital Auxiliary, Bremerton, Wash.

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Charter Member American Association of Fund-Raising Counsel

Hospital association meetings

(Continued from page 6)

1956

Hospital Volunteer Service Institute—January 5-6; Chicago (Knickerbocker Hotel)
Organization Planning Institute—January 16-18; Highland Park (Moraine Hotel)
Accounting and Business Practices for Small Hospitals Institute—January 23-27; Houston (Shamrock Hotel)
Evening and Night Nursing Service Institute—January 30-February 2; Chicago (Congress Hotel)
Hospital Personnel Institute—February 13-17; Kansas City, Mo. (Hotel President)
Hospital Planning Institute—February 13-17; Washington, D. C. (Sheraton Park Hotel)
Financial Management and Accounting Control Institute—February 13-17; Chicago (Congress Hotel)
Hospital Laundry Management Institute—February 15-17; Boston (Somerset Hotel)
Supervisory Training Workshop—February 27-March 2; Boston (Somerset Hotel)
Nursing Service Administration Institute—February 27-March 2; Portland, Oregon (Multnomah Hotel)
Medical Record Library Personnel Institute March 12-16; Salt Lake City (Utah Hotel)
Dietary Department Administration Institute March 12-16; Chapel Hill, North Carolina (Carolina Inn)
Hospital Laundry Management Institute—March 20-22; Atlanta (Henry Grady Hotel)

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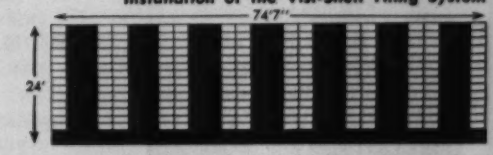
Floor Plan of an Actual Filing Area Before Installation of the Visi-Shelf Filing System



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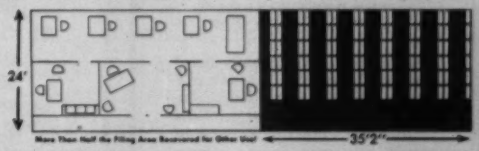

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Hospital Auxiliary Leadership Institute—April 24-25; Seattle (Ben Franklin Hotel)
Hospital Law Institute—May 14-15; Atlantic City (Traymore Hotel)
Insurance for Hospitals Institute—May 31-June 1; San Francisco (Sir Francis Drake Hotel)

The use and safe handling of isotopes

(Continued from page 57)

be obtained from the Bureau.

Handbook

No.
42 "Safe Handling of Radioactive Isotopes"
48 "Control and Removal of Radioactive Contamination in Laboratories"
49 "Recommendations for Waste Disposal of Phosphorous-32 and Iodine-131 for Medical Users"
51 "Radiological Monitoring Methods and Instruments"
52 "Maximum Permissible Amounts of Radioisotopes in the Human Body and Maximum Permissible Concentrations in Air and Water"
53 "Recommendations for the Disposal of Carbon-14 Wastes"
54 "Protection Against Radiations from Radium, Cobalt-60, and Cesium-137"
56 "Safe Handling of Cadavers Containing Radioactive Isotopes"
58 "Radioactive Waste Disposal in the Ocean"
59 "Permissible Dose from External Sources of Ionizing Radiation"

Finally, it is important to realize that in the operation of a radioisotope service program in a hospital, legal problems may arise in which interpretation of consequences of exposure to radioisotopes may differ from that relating to the use of other chemicals or drugs. The use of radioisotopes involve potential danger to not only the patient, but to the physician, the nursing and technical staff and to the public as a whole. The hospital administration should carefully consider the legal problems involved and seek proper advice in malpractice and accident insurance. ■

Don't fence the community out

(Continued from page 63)

same measure, do not owe the people?

As things look now, prepayment will in all probability be extended during the next ten years to cover practically every American but those institutionalized or chronically indigent. All the impulses in the prepayment movement, including those of the federal government, are on the positive side; and we might add, very aggressively on the positive side. It does not take a prophet to point out that a movement of this dimension, with a powerful political appeal added to its social need, cannot be built around any institution with an attitude that is both frustrating and disappointing.

My objective is not to plead the case for Blue Cross. Blue Cross, I am positive, will survive if the voluntary hospital survives. It is the survival of our voluntary hospital system that concerns me. And as I see it, the voluntary hospital is losing ground as an ideal, even as a community concept. To regain full confidence of the people it must realize the necessity for making prepayment and the establishment of a sound and broad prepaid program an active basis for working with the people, a cause for building the closest possible understanding with them.

All of us in the health field must realize our responsibilities to the American people, who have a right to look to us for guidance and leadership. There is no room among us, as far as prepayment is concerned, for benevolent indifference, for neutralism or parochial smugness. There is no room for the racketeer or the gyp policy promoter. There will always be room for hospital leaders who bring support to a true community concept of prepayment. ■

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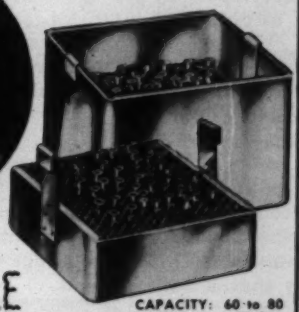

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c. 100 U. of HP*ACTHAR *Gel* for every 400 mg. of cortisone.

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PRO RE NATA

JOHN H. HAYES

Gripe of the Hospital Pharmacist
Dr. Smith says, "Buy from Squibb."
Dr. Jones likes Abbott.
Dr. Brown has preference too;
Parke, Davis is his habit.
So, in dispensing standard drugs,
It's ever my ambition
To learn, not who the patient is,
But who is his physician.
I wanted to include Eli Lilly, but didn't have enough lines.

★ ★ ★

I often wonder why doctors do not have hospital admission slips in their offices, to be filled out by them and sent to the hospital with their patients. We might get better information that way.

★ ★ ★

It is difficult to believe that the salt-free diet was developed by such humane people as doctors.

★ ★ ★

Sometimes we are apt to overlook the fact that deficits can also result from poor management.

★ ★ ★

I think it will be conceded that hospital work attracts beautiful women and handsome men. This disproves the theory that beauty is only skin deep.

Being one of the exceptions which prove the rule I feel that I can properly make this statement.

★ ★ ★

By the time a doctor becomes a Diplomate in his specialty, he is about 30 years old. It takes him an average of another five years before he is able to earn what a man of his learning should earn. Forgetting the high cost of his education, he then has only 30 years to average retirement age in which to make enough so that he can retire.

The average man has half again as much time in which to do it, plus Social Security and the possibility of additional pension money through his employers.

No wonder hospitals are always short of interns.

★ ★ ★

The "excess profits" of a firm or corporation often include sums which should have been expended for support of the voluntary hospitals of the community; in which event "excess profits" are well named.

★ ★ ★

In truth, the best social workers are mothers.

★ ★ ★

A good way to overwhelm a hospital pharmacist and get him sore is by asking all your doctors to bring to him all the free samples of drugs which they get in the mail.

★ ★ ★

I have learned over the years that, in addition to the annual printed receipt a hospital sends for a donation, a special letter written to the donor is most likely to bring about a repetition of the gift and, often, an increase in the amount.

★ ★ ★

Misquoting Eddie Guest: "It takes a heap of giving to make a hospital homelike."

★ ★ ★

The people who think there is no money in poetry evidently have failed to notice the size of monetary grants in breach of promise suits against amorous would-be poets.

★ ★ ★

It would be nice, wouldn't it, if everyone who buys an Irish Sweepstakes ticket at the same time gave a similar amount of money to his local hospital?

★ ★ ★

EASE-UP'S FABLES: Once upon a time there was a hospital superintendent who, during a period of ten years, had changed positions three times, due to differences with trustees and doctors and relatives of patients.

Upon finding it necessary to resign for the fourth time, he took the money he had saved out of his wife's dowry and opened a pet

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shop, where he spent his days painting greetings on the shells of live turtles.

MORAL: If you don't succeed after four attempts, you are just stubborn.

★ ★ ★

A good many new and good things in medicine were developed in old hospital buildings.

★ ★ ★

One of the nice things about being old is that your grandchildren love and respect you because you are old.

★ ★ ★

Some committee members get great pleasure out of criticizing the way in which the committee chairman does all the work.

★ ★ ★

I can't help but feel that many vice-presidents in large banks which have umpty-seven vice-presidents are equivalent to head nurses in large hospitals.

★ ★ ★

SNAKE HOLLOW HOSPITAL NOTES: The interns' and residents' floating poker game was finally broken up when a steam pipe burst in the boiler room.

The C.P.A. who does the hospital auditing says he will have to double his fee if we add to his work the auditing of the gift shop figures. The gift shop is operated by the ladies' auxiliary.

What is probably the all-time record for early ambulation was established the other day when our ambulance brought in a patient with a chicken bone in his throat. The ambulance collided with a doctor's car in our yard; and the bone was dislodged by the impact.

While the surgeons were discussing means of getting rid of the large number of flies in the operating room lately, a facetious intern suggested that all operations be performed during the lunch hour. He said that all the flies are in the intern's dining room at that time.

While the Committee on Nursing was determining upon an increase of $10 per month in salaries, the Building Committee increased the rent in the nurses' residence by a like amount.

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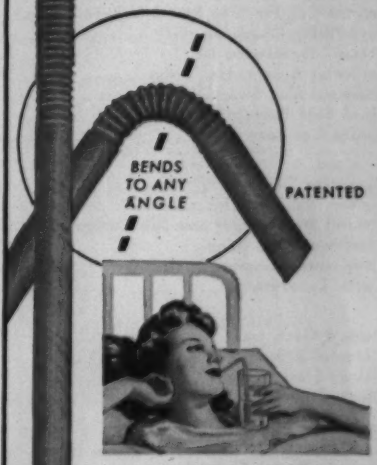

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New $500,000—25 bed hospital, air conditioned throughout, with ideal working conditions in a mild year-round climate receiving applications for REGISTERED NURSES. All applications must be in writing including full details concerning schooling and experience. All replies will be held confidential. Mail to Lafourche Parish Hospital Service District No. 1, P. O. Box 416, Golden Meadow, La.

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DIETITIAN, assistant to Chief. 160 bed general hospital. College town of 25,000, 20 miles west of Milwaukee. Modern dietary department completely remodeled in 1955. Write Robert M. Jones, Administrator, Waukesha Memorial Hospital, Waukesha, Wisconsin.

OB SUPERVISOR—Post graduate work in obstetrics and supervisory experience required. Immediate opening. Modern and up-to-date department. Social Security and excellent personnel benefits. Apply Director of Personnel, White Cross Hospital, 700 North Park Street, Columbus 8, Ohio.

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ANESTHETIST—NURSE for 250 bed general hospital. Excellent working conditions and personnel policies. Good starting salary. Write Mr. Bert Stajich, Assistant Administrator, Columbia Hospital, 3321 N. Maryland Avenue, Milwaukee 11, Wisconsin.

ADMINISTRATORS: (a) Medical; gen'l vol hosp (JCAH) 500 beds; impor tch'g prog; E. (b) Gen'l hosp, fairly lge size; construction starting early '56; lge city; MW. (c) Medical or non-med; impor gen'l hosp, lge size, affil univ med schl; lge city; E. (d) Gen'l hosp, fairly lge size operated under American auspices; So. America; knowledge of Spanish advantageous. (e) Medical; pref w/exper in hosp adm; med sch affil hosp, 600 beds; lge city, (f) 500 bed hosp primarily for treatment of TBc & chest diseases; req's trn'd hosp adm able reorganize bus adm dept; attrac offer; W-coast, (g) Non-medical; several units; 300 beds; Calif. (h) JCAH, gen'l hosp, fairly lge size; expansion prog; pleasant living in attrac univ & coll, county seat town, 30,000 pop. nr southern metropolis. (i) Non-medical exp'd in bldg program; gen'l vol hosp, 175 beds now expand'g; city, 300,000 on Great Lakes. (j) 100 bed hosp affil w/impor grp-clinic; approval pending; univ city, 100,000; W. (k) 100 bed gen hosp break'g ground soon; will engage adm 8 mo to 1 yr before opening; delightful res town; MW. (l) JCAH appr'd gen vol hosp 130 beds; county seat twn, 25,000 short distance univ; cooperative Board; MW. (m) JCAH, gen, vol hops, 125 beds; ocean town, Calif.

ADMINISTRATORS (WOMEN): (a) R.N.; also serve as dir of nurs; pref w/knowl Span; sm gen hosp under American, British, Canadian auspices; sal & full mtce; transp pd; tropic loca, (b) R.N. or non-med; vol gen hosp 75 bds; $6000; res twn nr Washington, D.C. (c) R.N. or non-med; 35 bd gen hosp & affil clin grp; lge univ med ctr; MW. (d) R.N.; female; 100 bd gen hsp affil very lge clin grp; Pac NW. (e) R.N. w/surg exp; new gen hosp 30 bds; lovely sm twn; Iowa.

ADMIN EXECUTIVE POSTS: (n) *Accountant;* qual to assume duties of business mgr; vol gen hosp small size; Rocky Mtn area. (o) *Bus Mgr* to work w/architect & bldg committee; new hosp project; coll twn 20,000; E. (p) *Clinic Manager;* public relations man, pref w/executive exper; one trn'd in clinical managmt desiring to move to larger group desirable; lge grp operates as partnership & corporation; resort center; SW. (q) *Clinic Manager;* Grp estab'd '35 staffed by 9 men; town 25,000; excel climate; SW. (r) *Clinic Manager;* long estab'd 12 man grp; new clinic bldg; expansion program; excel area, outdoor sports; NW. (s) *Comptroller;* impor tch'g hosp 650 beds; req's exper in supervisory capacity in hosp acctng field; E. (t) *Personnel Dir;* pref w/M.S. in personnel; gen hosp, 400 beds; will report dir to admin; about $6000; lge city, univ med center; MW. (u) *Purchasing Dir;* 800 bed teach'g hosp; req's college degree, exper in purchasing, business mangmnt; & indus engineering background; MW.

ANESTHETISTS: (a) Gen hosp 100 bds; $6000; fairly good sized twn; Alaska. (b) 75-bd gen hosp; $500, part mtce; lovely sm twn; Iowa. (c) Lovely sm hosp in ideal resort loca; $6500; 10 surg cases daily; Pac NW. (d) Fully apprv'd 300 bd gen hosp; $500; lge univ city; MW. (e) 2 hosps, total 130 bds; to $525; S. Calif. (f) More than 1; outstand'g lge clin grp; $600; lge univ med ctr; MidE.

DIETITIANS: (a) Admin; full resp, new dept; 400 bd gen hosp now u/constr; open fall '56; empl sev mos prior to open date; lovely lge city; SE. (b) Ass't food supv; very lge state mental hosp; to $5400; E. (c) Head dept; resp only to admin; JCAH appr'd 75 bd gen hosp; lovely resort twn 10,000; MW. (d) Chief; expand'g dept; some teach'g of diet ther; vol gen hosp 150 bds; delightful N. England coll twn.

DIRECTOR OF NURSES: (a) Nurs serv & ed; resp only to admin; 500 bd gen hosp; outstand'g facil; $7500 start; lovely lge city; MW. (b) Nurs serv incl in-serv trng prog; vol gen hosp 200 bds; to $6000; NW. (c) Nurs serv & ed; appr'd 200 bd gen hosp; to $6000; twn 10,000; E. (d) Total respon, new 400 bd gen hosp sched to open fall '56; will empl sev mos prior to opening date; org & est trng sch; lovely lge city; SE. (e) Nurs serv & ed; qual ass'ts in both; med sch affil gen hosp 300 bds; 70 students; to $7000; E. (f) Nurs serv & ed; 1 of finest teach'g hosps in So; ideal lge city. (g) Nurs serv & ed; top flight ass'ts in each area; JCAH gen hosp 350 bds; exceptional facil; $6,000, full mtce; lge city; MidE.

EXECUTIVE HOUSEKEEPERS: (a) Supv staff of 75; 400 bd univ hosp; Calif; pref appl from Calif area. (b) Lge gen hosp; med sch affil; $375, apt in hosp for $25; lge univ city; SE. (c) Fully apprv'd 250-bd vol gen hosp; lovely twn 50,000 nr larger city; So. (d) Gen hosp 250 bds; affil impor med sch; delightful city; Pac NW. (e) Exp'd req; JCAH hosp 120 bds; res twn nr NYC.

FACULTY POSTS: (a) Assoc ed dir; fully apprv'd 500 bd gen hosp; to $5200; Rocky Mtn area. (b) Ed dir; excel med staff & sch faculty; 60 students; temp NLNE accred; gen hosp 400 bds; res twn nr NYC. (c) Ed dir; 150 students; very lge gen hosp; outstand'g facil; gd sal, mtce avail; lge univ city; So. (d) Ass't ed dir; 50 students in state accred sch; 200 bd gen hosp; rapidly growing med ctr; E. (e) Clin instr. med & surg; 400 bd gen hosp affil impor med sch; lge city; So. (f) Psych nurs instr; lge state sch; to $5000; N. England. (g) Nurs arts inst; 400 bd gen hosp; bldg prog just comp; 150 stud, state accred sch; attrac twn 50,000; MidE.

SUPERVISORS: (a) Ob; 35-bd unit; teach'g req'd; vol gen hosp 300 bds; $4200; resort twn nr NYC. (b) OR; sm gen hosp; JCAH apprv'd; $4500; attrac sm twn; SW. (c) OR; active surg serv; 6-rm suite; staff of 15 in add'n to stud; 300 bd gen hosp; excel pers pol; twn 50,000; N. England. (d) OR; pref p/g trng; JCAH vol gen hosp 100 bds; $4800; attrac twn 15,000; Pac NW. (e) OB; 65-bd unit; 2 firs & delivery rm suite; some teach'g; coll affil schl; lge gen hosp; E.

THE MEDICAL BUREAU

M. Burneice Larson—Director

Palmolive Building

Chicago 11, Illinois

ADMINISTRATORS: (a) Medical director to take complete charge of medical services, clinics and laboratories in dynamic hospital setting; large hospital specializing in psychiatry; East. (b) Medical director; duties consist of directing educational program, coordinating all medical aspects; voluntary general hospital, 500 beds; East. (c) General 250-bed hospital affiliated university operated under American auspices, foreign city; duties include conducting program for hospital administrators. (d) General 125-bed hospital functioning essentially as community hospital for British and American colonies in foreign country; expansion program; $12,000; cost of living between ½ and 2/3 of US. (e) General hospital, 60 beds; expansion program increasing to 120; resort city, Florida. (f) Assistant; large general hospital affiliated medical school; altho medical preferred, non-medical eligible; opportunity succeeding director within two years. H12-1.

ADMINISTRATORS: WOMEN: (a) Modern, small hospital; attractive city outside US; English-speaking staff. (b) New 40-bed hospital; completion early 1956; available soon to engage staff; wealthy agricultural area; Midwest. H12-2

ANESTHETISTS: (a) General 150-bed hospital; resort town, near two university cities; Midwest; $500-$650. (b) New small hospital; salary or free lance; Texas. (c) Small general hospital; Hawaii. (d) Association, 20-man group; modern 200-bed hospital; medical anesthesiologist; top salary; college town, Midwest. (e) Staff;

CLASSIFIED ADVERTISING

MEDICAL BUREAU—(Cont'd)

large general hospital; greater New York area; $4800, maintenance. H12-3

DIETITIANS: (a) Chief; 200-bed modern hospital; year-round resort area; $6000. (b) Chief; new 300-bed general hospital affiliated medical school; Pacific Coast. (c) Assistant; teach therapeutics; well equipped department; largest hospital in state; South; $6000. (d) Chief; new general 225-bed hospital; completion March; university city, South. H12-4

DIRECTORS OF NURSING: (a) Dual responsibility, school and service; 500-bed general hospital; college town, California; $7500. (b) General 400-bed hospital currently under construction; completion late 1956; preferably one available early part of 1956 in order to organize departments; university city, South. (c) Director, school; general 500-bed hospital; 90 students; university city, Midwest; $6000-$7200. (d) Nursing service; $3,000,000 building program; large teaching hospital; West Coast. (e) Associate director; 300-bed general hospital operated under American auspices, foreign country; $7500, maintenance. H12-5

EXECUTIVE HOUSEKEEPER: General 400-bed hospital, unit of univeristy medical center; expansion to 800; university city; $4200-$4600, attractive apartment. H12-6

EXECUTIVE PERSONNEL: (a) Comptroller; 900-bed general hospital; supervisory experience required; East. (b) Directors of personnel and purchasing; 400-bed general hospital; university city, South. (c) Food Manager; university hospital, 450 beds; East; $7000. H12-7

FACULTY POSTS: (a) Director, vocational nursing program; collegiate affiliation; attractive location, Pacific Coast; $500-$750. (b) Assistant professor, nursing arts; renowned university. (c) Assistant director, nursing research; 500-bed teaching hospital; university center, Midwest. (d) Educational director, qualified organize new university program; Northwest. H12-8

RECORD LIBRARIAN: (a) Chief; teaching hospital; $5,000-$6,000; greater New York area. (b) Chief; general 400-bed hospital currently under construction, completion late 1956; preferably one available early part of 1956 in order to establish department; university city, South, (c) New small general hospital; ideal coast resort city, Florida. H12-9

SUPERVISORS: (a) Operating room; 200-bed general hospital with expansion program to 425; busy surgery; college town; California. (b) Evening and pediatric supervisors; duties: teaching and administration; 200-bed hospital affiliated university; 70 students; Near East. (c) Floor supervisor and ability to act as director of nurses, 25-bed new hospital; ideal Florida location. (d) Obstetrical, medical, surgical; 250-bed general hospital; free tuition at affiliating college, NYC area; $4500. H12-10

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EXECUTIVE PERSONNEL: (a) Purchasing Agent. Middle West. One of countries leading hospitals. $7500. (b) Accountant. South. 100 bed hospital. Supervise personnel in business office—prepare statistical statements. $4800-6000. (c) Public Relations Director. South. Large hospital. Require good public relations experience and sound comprehensive knowledge of human relations. $7000-10,000. (d) Business Manager. Middle West. 250 bed hospital in large city. $6000. (e) Assistant Administrator. Southwest. Accounting experience required. 135 bed hospital. (f) Clinic Manager. Southwest. 25 physicians in group—50 employes. New modern building. $8000-10,000. (g) Purchasing Agent. South. 300 bed hospital in large city. $6000. (h) Business Manager. Middle West. 80 bed hospital in college town of about 10,000. $6000. (i) Business Manager. East. Private clinic—25 physicians. Excellent opportunity. $6000-8000. (j) Director of Building Services. West. Will act as assistant supt. Large hospital. Some college engineering training, plus experience. $7000.

MEDICAL TECHNOLOGISTS: (a) East. 500 bed hospital. Laboratories all new and modern. Must be A.S. C. P. to $6500. (b) Chief. California 160 bed hospital near San Francisco. $470. (c) Chief. East. Complete supervision of laboratory. 4 years experience at least. 250 bed hospital. $475. (d) Chief. Middle West. Supervise 2 clinical laboratories under direct supervision of certified pathologist. $500. (e) South. 125 bed hospital. 3 technologists in laboratory. $325. (f) Pacific Northwest, 100 bed general hospital, fully approved. $375 (g) Blood Bank. Middle West. 100 bed hospital in small college town. Can continue work toward degree if desired: $350-$400. (h) East. Blood chemistries and some bacteriology. 200 bed hospital. $300 plus maintenance.

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Miss Elsie Dey, Director

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ADMINISTRATOR: 50 bed hospital, Ohio. (b) 100 bed hospital, New York. (c) 60 bed Hospital, east. (d) Assistant. 250 bed hospital, western Pennsylvania. Also Administrative Assistant. (e) R.N. 35-50 bed hospitals, mid-west.

DIRECTORS OF NURSING: 400 bed Ohio hospital. (b) 250 bed hospital, near Washington, D. C. (c) 175 bed hospital, midwest. (d) Assistant Directors and Educational Directors. To $6,000.

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ADMINISTRATOR—Hospital administration graduate or experienced; new Apple River Valley Memorial Hospital now considering applications; 30 expandable to 40 beds. Give education, experience, references and acceptable starting salary. Send formal application to John G. Decker, Chairman, Amery, Wisconsin.

ASSISTANT MEDICAL DIRECTOR, 100 bed tuberculosis hospital, North American Graduate, salary $8500, complete maintenance apply Medical Director & Superintendent, District Five Tuberculosis Hospital, London, Kentucky, or State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

RADIOLOGIST—Full-time Associate. Certified. 486-bed general hospital. Very active department and fully equipped for x-ray work. Opportunity for qualified Radiologist. Excellent remuneration. State training, experience, availability, marital status, etc. Apply to Director, The Royal Columbian Hospital, New Westminster, British Columbia, Canada.

A qualified PHYSICAL THERAPIST for a rapidly growing physical therapy department in a 200-bed general hospital, salary commensurate with experience and qualifications. For information, write to Audrey Shade, Administrator, St. Luke's Hospital, Marquette, Michigan.

CLINICAL INSTRUCTOR IN MEDICAL NURSING and CLINICAL INSTRUCTOR IN MATERNITY NURSING—Liberal personnel policies. Good educational opportunities. Salary open. For further information contact: Director of Nursing, Presbyterian Hospital, Chicago 12, Illinois.

LABORATORY TECHNICIAN, for general hospital work in small institution. Knowledge of x-ray technique preferable but not required. Ideal location for ski enthusiast. Apply Administrator, The Memorial Hospital, North Conway, N. H.

MEDICAL DIRECTOR, North American Graduate, five years Tuberculosis experience, relatively new 100-bed tuberculosis hospital, salary $10,000, complete maintenance. Apply State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

REGISTERED MEDICAL RECORD LIBRARIAN for 212 bed general teaching hospital. Write ass't Admin., Mt. Sinai Hospital, Minneapolis 4, Minn.

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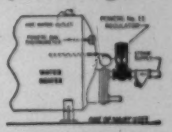

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THE MEDICAL BUREAU

M. Burneice Larson—Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATOR: Medical; three years, assistant administrator and six years, administrator, voluntary general hospital, 350 beds.

ADMINISTRATOR: M.B.A. (Hospital Administration); administrative residency, teaching hospital; six years, administrator, 225-bed general hospital, during which time hospital reached new levels of achievement and financial stability.

ANESTHESIOLOGIST: Diplomate; eight years, private practice and director department, 200-bed hospital.

COMPTROLLER: C.P.A.; five years' experience as public accountant; since 1950, comptroller, 400-bed hospital.

DIRECTOR OF NURSING: M.A. Nursing Administration, Columbia University; twelve years, assistant director, nursing, three years, director, 350-bed hospital.

PATHOLOGIST: Diplomate (Pathologic Anatomy; Clinical Pathology); three years' full time teaching; six years, director of pathology, 300-bed general hospital.

PERSONNEL DIRECTOR: A.B., considerable work toward M.B.A. (Personnel Management); six years' hospital personnel experience.

PURCHASING DIRECTOR: B.S. State university; six years, purchasing agent, 250-bed hospital.

RADIOLOGIST: Diplomate (Diagnostic and Therapeutic X-ray, Radium); trained in isotopes; since 1951 in private practice; prefers directorship hospital department.

ADMINISTRATOR: 16 yrs exper; seeks warm climate; size not impor but must exceed 100 beds; past 4 years, admin, 350 bed gen'l hosp; excel references; late 40's; Norwegian; will consider assistantship; Member, ACHA.

ADMINISTRATOR: B.A. MS, (hosp adm); years' hosp adm res; past 5 years, ass't adm, impor hosp; seeks admin, hosps 100 beds up; any locality; early 30's; Member, ACHA.

ADMINISTRATOR—Woman R.N.; 25 yrs admin exp; incl 5 as admin, 60 bed gen hosp & 7 as admin, 75 bd gen hops; similar posi; Calif only; MACHA.

ADMINISTRATOR, (Ass't); 28; MS (hosp adm); 8 yrs, hosp & clinic exper includ'g 2 yrs, hosp adm res & 2 yrs, adm, 40 bed gen hops; seeks assistanship, lge hosp.

ANESTHETIST—Male; reg'd; past 7 yrs, private anes, lge SW city; seeks similar posi or fee-for-service basis; early 40's.

DIRECTOR OF NURSES—female; some cred twd B.S. nursing ed; sev yrs staff, supv, various hosps; past 2 yrs, dir of nurs 50 bd gen hosp; similar posi; SW only.

DIRECTOR OF NURSES—female; 50; B.S.; 20 yrs exp, faculty, ed dir & dir of nurses, various hosps; pref psych hosp, consider gen; East only.

EXECUTIVE HOUSEKEEPER—sev yrs hotel exp; 1 yr hosp exp; seeks posi, fairly sm gen hosp; SE only.

MEDICAL RECORD LIBRARIAN—early 30's; Canadian reg; sev yrs exp, med sec'y; past yr, med rec libr, 100 bd gen hosp; seeks similar posi. MW & E. seaboard.

PATHOLOGIST: Dipl, (both branches); trn'd Johns Hopkins; 2 yrs, neurologist, impor Army hosps; 2 yrs, instructor, path, univ hosp; 3 yrs, research, path, includ'g 1 yr, research fellow, impor foreign research institute; currently assoc chief path, 1500 bed hosp; seeks chiefship, any locality pref East or West seacoasts; early 30's.

PURCHASING DIRECTOR: 12 yrs, purchasing dir & stores keeper, 500 bed gen'l hosp; prefers area, 600 mile radius, Toledo, Ohio; consider others; Member NAPA; experienced man; early 40's; $5500.

RADIOLOGIST: 31; Dipl; well qual, rad physics; 2 yrs, ass't rad, univ med center; prefers Calif, Fla, Conn, NY; licensed Texas, Calif, Fla, N.Y.; trn'g finished; Cat IV; exempt.

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Miss Elsie Dey, Director

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ADMINISTRATOR: 2 years Medical College. 22 years experience in 125-300 bed eastern hospitals.

BUSINESS MANAGER: M.H.A. Degree, 1951. 4 years Business Administrator, midwestern hospital. Desires change.

NURSE ADMINISTRATOR: Outstanding nurse executive. 6 years Director of Nursing, 100 bed hospital, 8 years Administrator, 65 bed Ohio hospital.

DIRECTOR OF NURSING: B.S. Degree. Experience: Educational Director, and Assistant Directress, 10 years; 15 years Director of Nursing and Schools of Nursing. Registered Illinois, Ohio.

EXECUTIVE HOUSEKEEPER: Course in Institutional Management. 5 years hotel experience; Past 3 years, 300 bed N. J. hospitsl.

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HOSPITALS

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18 East Division Street, Chicago 10, Illinois

THE INDEX

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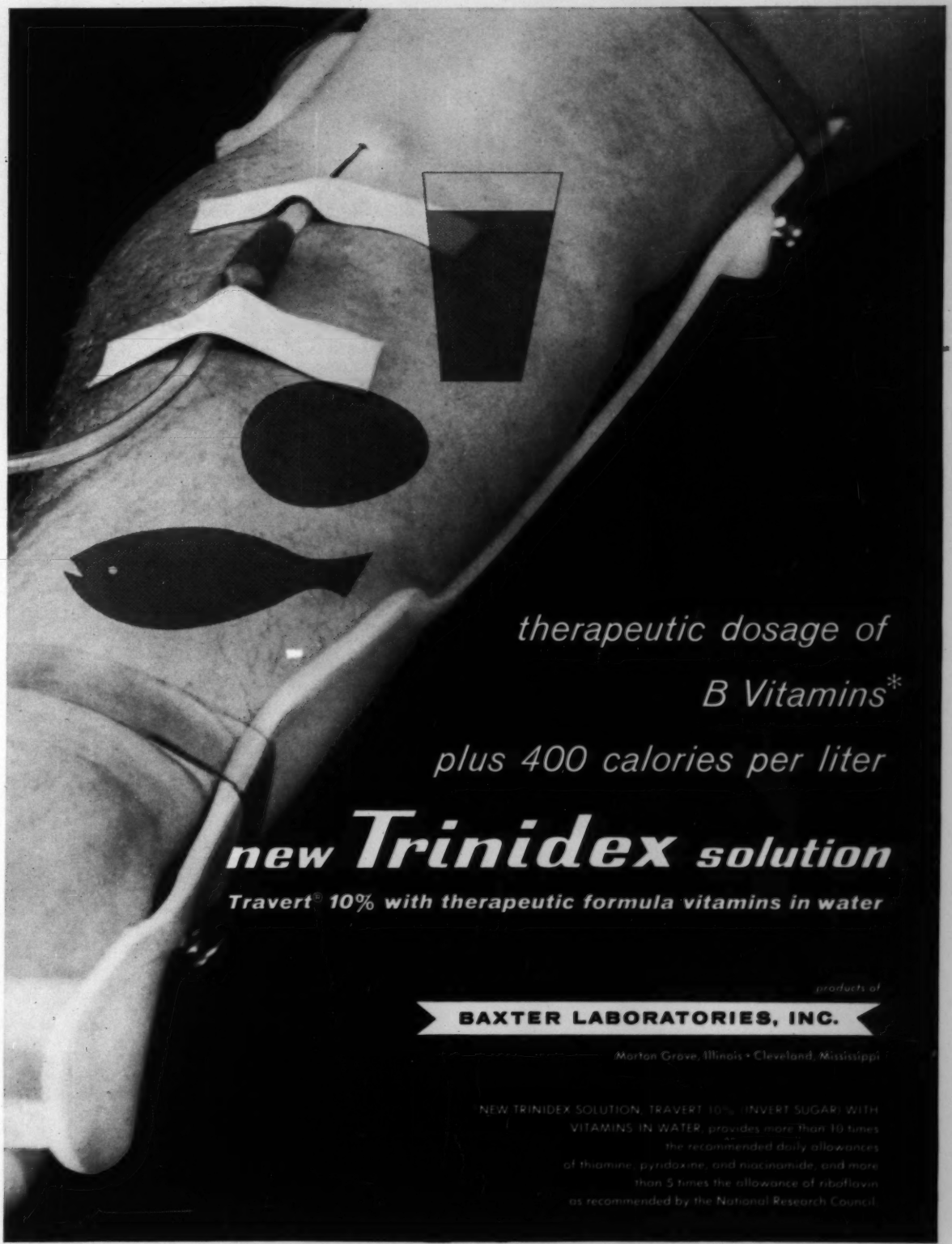
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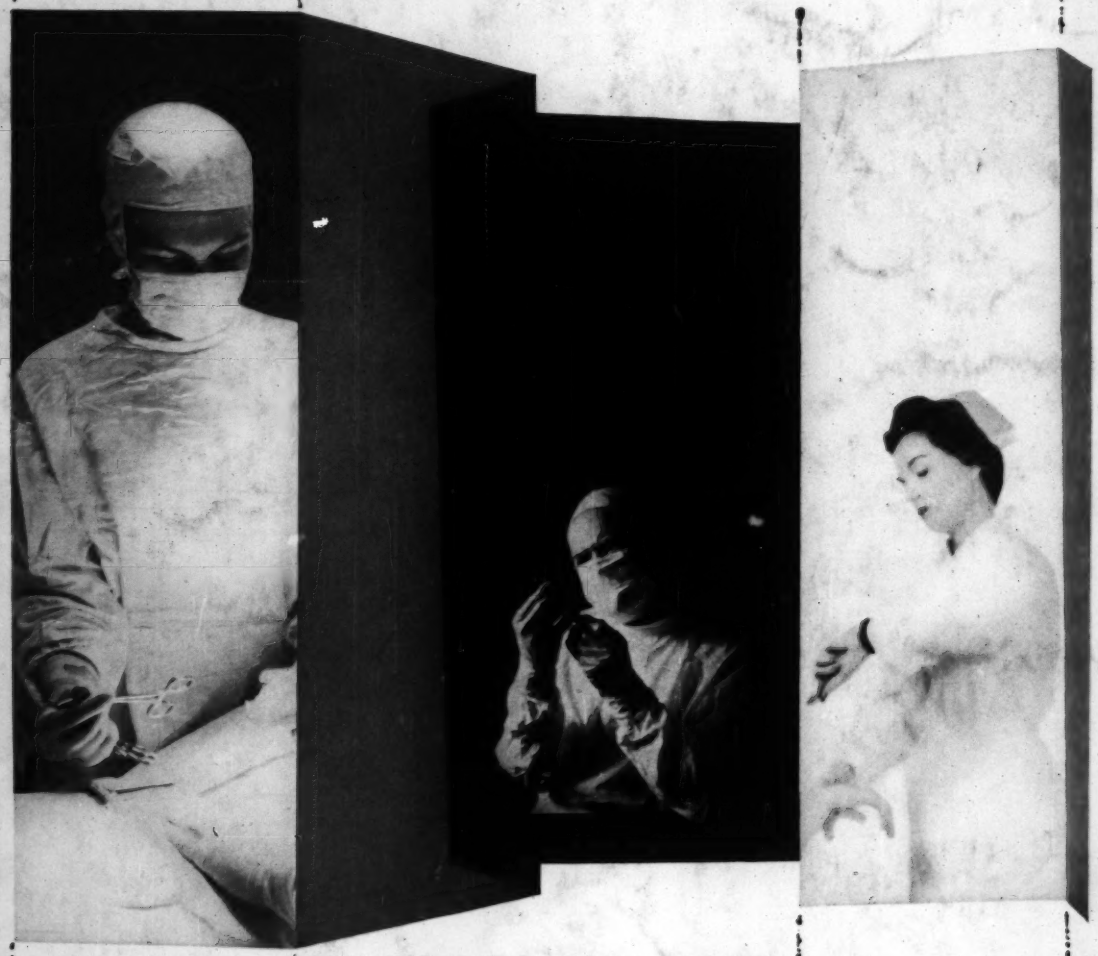
AMERICAN HOSPITAL SUPPLY CORPORATION

SCIENTIFIC PRODUCTS DIVISION GENERAL OFFICES • EVANSTON, ILLINOIS



MAKES THEIR WORK EASIER

SURITAL® sodium

ultrashort-acting intravenous anesthetic

the surgeon: SURITAL facilitates the surgeon's work by assuring fewer interruptions due to laryngospasm, to bronchospasm, or to respiratory or circulatory depression.

the anesthesiologist: Smooth, speedy induction, readily controlled surgical plane of anesthesia, and fewer postoperative complications with SURITAL ease the task of the anesthesiologist.

the nurse: Prompt recovery, usually without nausea, vomiting, or excitement, characterizes anesthesia with SURITAL...and thus lightens the nurse's burden.

Detailed information on SURITAL sodium (thiamylal sodium, Parke-Davis), as an anesthetic agent alone or in conjunction with other anesthetics, is available on request.

MEDICAMENTA VERA

PARKE, DAVIS & COMPANY DETROIT, MICHIGAN